

The 2005 Thunder Bay Street Youth Drug Use Questionnaire

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Table of Contents

4	List of Tables
6	List of Figures
7	Executive Summary
10	Background Information Thunder Bay District Health Unit / 10 The Project / 10
12	Project Summary Goals /12 Purpose / 13 Benefits to Target Population / 13 Benefits to Community Members / 13 Scope of Project / 13
13	Methodology Target Population / 13 Sampling / 14 Peer Outreach Workers / 14 The Questionnaire / 15 Procedures / 15 Data Analyses / 16 Peer Outreach Journals/17 Limitations of the Study / 17
19	Results 1. Demographics / 19 2. Drugs Used / 21 a. Drugs of Choice / 22 b. Drugs of Convenience / 25 c. Differences between Drugs of Choice and Convenience / 28 d. Drugs Used During the Previous Six Months / 30 3. Shared Works (Previous and Current) / 32 4. Access and Use of Condoms When Sexually Active / 36 5. Accessibility to the Health Care System / 38 6. Community Development /40 7. Participants Final Comments/ 42
44	Discussion and Recommendations
51	References
52	Appendix A – Thunder Bay Youth Drug Use Questionnaire
55	Appendix B – Peer Journal Comments
58	Appendix C – Contact Information for the Thunder Bay District Health Unit

List of Tables

20	Table 1.	Demographics and Drug Use.
21	Table 2.	Injection Drug Use by Age and Gender.
21	Table 3.	Cross-tabulation of Status of Previous Injection Drug Use and Knowledge of an Injection Drug User.
22	Table 4.	Drugs of Choice by Drug Category.
23	Table 5.	Drugs of Choice and Routes of Administration.
25	Table 6.	Drugs of Convenience by Drug Category.
26	Table 7.	Drugs of Convenience with Routes of Administration.
28	Table 8.	Reasons for Differences between Drugs of Choice and Convenience.
30	Table 9.	Drugs used During the Previous Six Months by Drug Category (multi-response set).
31	Table 10.	Frequency of Drugs used During the Previous Six Months by (Multi-response Set).
32	Table 11.	Access and Use of Clean Works.
32	Table 12.	Current and Previous Sharing of Works.
33	Table 13.	Cross-tabulation of Current and Previous Sharing of Works.
33	Table 14	Sharing of Works (Current and Previous) vs. Accessing and Use of Clean Works.
33	Table 15.	Shared Works (Current and Previous) by Route of Administration (Multi-Response Set).
34	Table 16.	Frequency of Pipe Sharing.
35	Table 17.	Reasons for Current and Previous Sharing of Works.
36	Table 18.	Frequency of Condom Use when Sexually Active.
36	Table 19.	Access to Free Condoms.
38	Table 20.	Accessibility to the Health Care System.

- 39 Table 21. Cross-tabulation of Health Care Access vs Difficulties Accessing Health Care.
- 41 Table 22. Community Development.

List of Figures

- 11 Figure 1. Superior Points Harm Reduction 2004 Year End Statistics
 Number of Client Visits and Referrals (2000 – 2004)
 Number of Needles Exchanged (2000 – 2004)

Executive Summary

“An individual that was clearly high or on something – exhibited many signs of it as well...inability to make eye contact, glossy red eyes, broken speech - . Said he never didn’t do drugs. It sure seemed like he ways lying but I guess there wasn’t a whole lot I could do.” Peer Worker

The “2004 Thunder Bay Street Youth Drug Use Questionnaire” was an initiative by the Superior Points Harm Reduction Program of the Thunder Bay District Health Unit for The Public Health Agency of Canada Healthy Environments and Consumer Safety Branch, Ontario Region Drug Strategy Community Initiatives Fund. This project began in December 2004 and ended March 30, 2005.

The purpose of this project was to identify the drug use prevalence among street-involved or at-risk youth, aged 24 years and under, living in the District of Thunder Bay, who use or at risk of using drugs, and to develop recommendations for the Thunder Bay District Health Unit regarding drug use prevention and harm reduction strategies, tools, and programs targeted for this group. Data from this research may be useful in decision-making in other communities in Northern Ontario. The data will also provide a baseline from which the effectiveness of future harm reduction programming may be evaluated.

Research on this population is lacking. The Ontario Student Drug Use Survey (Sieswerda & Adlaf, 2002) has limitations of not accessing this population.

This study employed Peer Outreach Workers to collect the data as Thunder Bay District Health Unit staff did not have stable connections with the intended target population. The development of this project involved a multi-disciplinary team of frontline harm reduction workers, an epidemiologist and consultants. The data collection tool was developed by this team and focus testing was done at a local youth homeless shelter. Feedback was incorporated into the final data collection tool. Five peer outreach workers were hired based upon their ability to access the population at risk and its diverse subcultures. Attention was also paid to the sensitivity of ethnicity with an emphasis on the Native population of the Thunder Bay District.

The outreach workers were committed to the project. They exceeded all expectations as they volunteered many hours over their contracted time and provided anecdotal insight into the youth drug using culture.

Data was collected on each individual’s (1) demographics; (2) drugs used; (3) sharing of works (previous and current); (4) access and use of condoms when sexually active; (5) accessibility to the health care system; (6) community development; as well as (7) any final comments or information participants thought was important to add.

Three hundred and thirteen questionnaires were completed within five communities in the District of Thunder Bay. The majority were collected in the City of Thunder Bay.

Data was collected during the winter season which may have had an impact on access to high risk individuals. The division of participants by ethnicity and gender were similar. The majority of respondents were under the age of 24 years.

Results of the study indicated a high prevalence of Central Nervous Systems (CNS) stimulant use among the target population. This has been an under recognized trend in the community. The predominant category of drugs of choice was CNS stimulants with Cocaine and Marijuana (n = 84 each) being the most frequently cited drug of choice. The predominant convenience drug category, as well as drug of convenience, was marijuana (n = 138).

The prevalence of Methamphetamine (Meth) use was higher for convenience drugs than drugs of choice. Anecdotal information from one of the peer outreach workers was that there were six active Methamphetamine labs in Thunder Bay during the beginning of data collection in January 2005. At the end of data collection, three months later, two outreach workers reported 24 active Meth labs. One of the participants indicated that they were a Meth cook. Thunder Bay is just beginning to see the 'Meth Wave' which has devastated other communities. Methamphetamine use, because of its low cost and possibly increased accessibility which is consistent with the sample's reasons for a convenience drug, will increase.

The spread of disease and infection, such as HIV and Hepatitis, through the sharing of drug paraphernalia or equipment which may contain blood or transmittable viruses is well documented in the literature. Public education initiatives have attempted to address this, yet the majority of respondents continue to share their works with the major reasons being cost, availability and access. Education needs to continue.

Further harm reduction strategies should include the continuation of distribution of sterile works including injection supplies. The spectrum of distributed works should also be expanded to include pipes, sterile snorting equipment, and drug test kits. Pipes and snorting equipment are works that if shared may contain blood or other transmittable viruses and consequently can spread disease and infection. Drug test kits would allow individuals to know what drugs they are taking.

Clean works need to be available and easily accessible. Regardless of the availability and accessibility youth may have hesitations doing so. Harm reduction education on the safe use of works, as well as the spread of infection and disease through the sharing of works needs to continue.

Harm reduction education should target this population directly. Barriers need to be identified and overcome. Education on what works are available and how to access them would be beneficial. An education campaign should be conducted surrounding the accessibility of clean works which should stress confidentiality, non-judgmental support, and no fear of reprisals or sanctions.

Consideration of "Safe Injection Sites" and prescription Heroin should be considered as ongoing research as these strategies are proving effective. Another focus in the reduction

of harm at the judicial level is the further decriminalization of drug use as it may promote sustained behavior change. Haden (2002) asserts “the desired end result is an evolution of our illegal drug laws and policies. Canadian society will not manage its “drug problem” effectively until we reach a place where addiction is viewed first and foremost through the lens of public health, and addicts and drug users are treated with dignity and respect.”

Background Information

The Thunder Bay District Health Unit

The Thunder Bay District Health Unit (TBDHU) is dedicated to the principles of public health. It is their mandate to promote health and primary prevention in accordance with specific legislation from the Ministry of Health and Long Term Care for the District of Thunder Bay. As one of 36 health units across the province of Ontario, the TBDHU complies with the Health Protection and Promotion Act (1988) and the Ministry of Health's and Public Health Branch 'Mandatory Health Programs and Services Guidelines' (1997).

The TBDHU carries out three fundamental roles. It is responsible for the delivery of provincial public health programs designed to meet provincial standards in the areas of chronic disease and injuries, family health and infectious disease. It coordinates clinical and specialty services in the areas of dental and sexual health, needle exchange, genetic and speech audiology. The health unit also offers unique resources to the District of Thunder Bay, including access to up-to-date health status information, population health program planning and health communications.

The health unit is a non-profit, government agency funded 40% by the municipalities it serves and 60% by the provincial government. It is governed by a Board of Health, which is comprised of 12 municipal representatives and three provincial appointees.

The Project

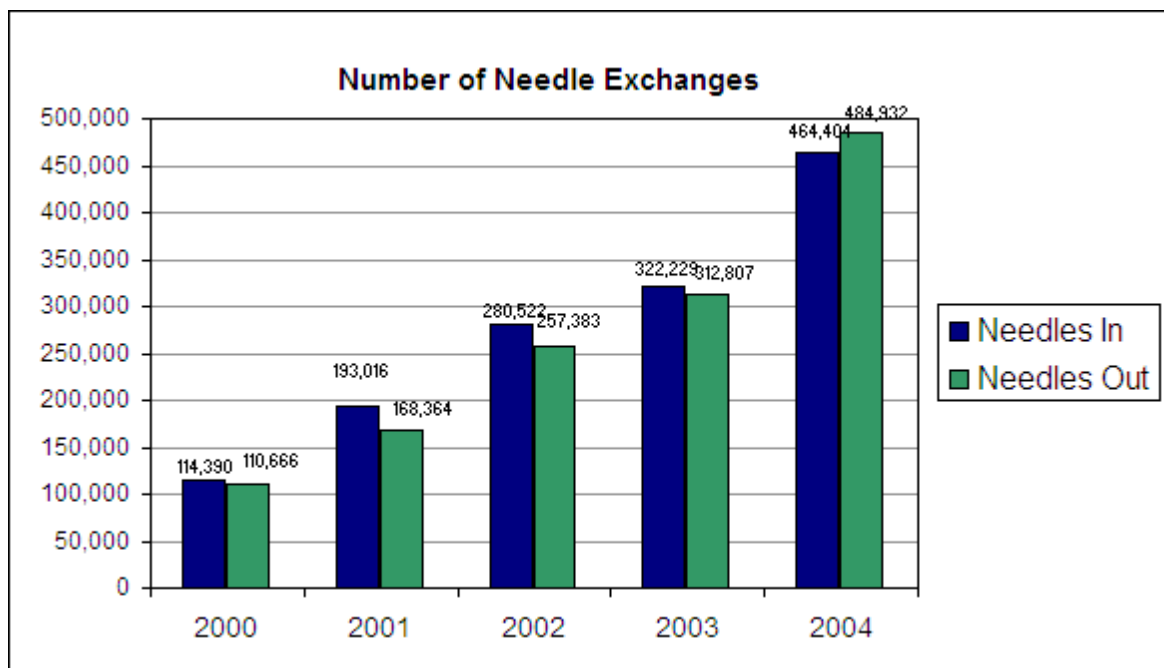
Superior Points Harm Reduction Program (SPHRP) is a program supported by the TBDHU and other community agencies such as Shelter House Thunder Bay and Haven House (a Salvation Army youth shelter in Thunder Bay) that provides harm reduction services to a wide range of high-risk individuals including both street-involved and intravenous drug users. Previous statistical and anecdotal information collected by SPHRP, indicated that the number of youth aged 24 years and under living on the streets of Thunder Bay is increasing and that drug use among this population is prevalent.

Statistics from SPHRP's Needle Exchange Program indicate that drug use in Thunder Bay has increased (Figure 1). From 2003 to 2004, there was a 44% increase in needles collected by the program and a 55% increase in needles given out.

Figure 1.

Superior Points Harm Reduction 2004 Year End Statistics

Year	# of Client Visits	# of Referrals	# of Needles In	# of Needles Out
2000	1,239	78	114,390	110,666
2001	1,755	64	193,016	168,364
2002	2,036	74	280,522	257,383
2003	2,405	140	322,229	312,807
2004	2,309	203	464,404	484,932
Total	9,744	559	1,374,561	1,334,152



The extent of the youth problem is reflected in the fact that 101 of 447 Hepatitis C infected individuals (22.6%) contacted through SPHRP's Hepatitis C Street Outreach Program, funded through TBDHU for Health Canada Public Health Branch, Ontario Region, Hepatitis C Program, were less than 21 years of age.

Furthermore, Haven House, a Salvation Army youth shelter located in Thunder Bay, report that bed-night statistics for 2004 have increased. This is further evidence of the increasing number of homeless youth in Thunder Bay. Two thousand-seventy bed-nights have been occupied by youth between January 1, 2004 and June 30, 2004. This suggests that Haven House will experience a large percentage increase over the total of 3,255 bed-nights reported in the 2003 period.

Furthermore, anecdotal information provided by Shelter House Thunder Bay confirms that the number of youth aged 24 years or under seeking short-term shelter from the streets has increased and high risk drug use among this population is common.

Despite the reported increase in youth living on the streets and the prevalence of drug use among this population, no programs currently exist in Thunder Bay to support drug use prevention or harm reduction for this population.

Before now no drug use prevalence studies have been conducted among high-risk youth or street-involved youth in Northwestern Ontario. Drug use among youth attending school in Northwestern Ontario has been studied (Sieswerda & Adlaf, 2002. The 2001 Northwestern Ontario Student Drug-Use Survey. Thunder Bay, Ontario) using a lengthy paper-and-pencil questionnaire delivered in schools. Results indicate an increase in drug use from 1997 to 2001. The sample, however, did not include individuals who were not in school, such as drop-outs and graduates. Additionally, some particularly at-risk individuals within the school setting may have not fully completed their questionnaires due to length, lack of literacy, or lack of engagement.

Primary data collected in Northwestern Ontario from street youth is required to validate the prevalence of drug use among this high-risk population and to assist with the development of prevention and harm reduction programming.

Project Summary

Goals

To acquire baseline data through conducting primary research on the drug use habits and trends of street youth aged 24 years of age and under living in Thunder Bay, Ontario. Representative drug use data for this target population has never been collected on a local, provincial, or national level.

Purpose

The data collected would be used to identify the drug use prevalence among street-involved or at-risk youth, aged 24 years and under, living in the District of Thunder Bay, who use or are at risk of using drugs and to develop recommendations for drug use prevention and harm reduction strategies, tools, and programs targeted at this population.

Benefits to Target Population

Since no drug use prevention or harm reduction program currently exists for street-involved or at-risk youth aged 24 years and under, living in the District of Thunder Bay, who use or at-risk of using drugs, the data collected and subsequent recommendations for programming would help the Thunder Bay District Health Unit develop unique and necessary services for this target group if the opportunity to access funding arises.

Benefits to Community Members

The research collected would be unique and unduplicated by previous surveys of youth in Northwestern Ontario. The 2004 Thunder Bay Street Youth Drug Use Survey will be crucial to support community partners in securing funds to support the development and implementation of primary and complimentary programs and services for high-risk youth.

Scope of Project

The project will provide local data on the prevalence of drug use among high-risk youth. Data from this survey may be useful in decision making in other communities in Northwestern Ontario. The data would provide a baseline from which the effectiveness of subsequent harm-reduction programs can be evaluated.

Methodology

“I went to a north side bar and completed 2 surveys. As well as arranged a time to do another. Both people I surveyed were reluctant at first but once they read the purpose they were more than happy to give me their time. Some asshole vomited on my bag. The surveys survived but that little brown stain on the corner of the pages is vomit, F----- GROSS” Peer Outreach Worker

Target Population

The target population of this research was street-involved and at-risk youth aged 24 years or under, living in District of Thunder Bay, who currently use or are at-risk of using drugs. The drug use prevalence of this population has not been captured by other mainstream drug prevalence surveys conducted within Ontario.

Sampling

Sampling used in this study was purposive or judgmental sampling. Since no programming or services delivered to this population exist in Thunder Bay, and the TBDHU does not have stable connections with the target population, the sampling strategies for this study consisted of ‘purposive or judgmental’ strategies through the hiring of peer outreach workers, who had connections with the desired target population.

Purposive or judgmental sampling includes all possible cases that fit particular criteria using various methods which are expected for special populations. It uses judgment of an expert in selecting cases with specific purposes in mind. Purposive sampling is used in exploratory research or field research where it is difficult to select members of a difficult to reach population (Newman, 2003). Consequently one relies on the judgment of the experts and their knowledge of the target population.

Peer Outreach Workers

“Man now I don’t want to sleep. I wanna GO! Do surveys, find people, help.” Peer Outreach Worker

Recruitment of the peer outreach workers occurred through a poster on the job board at Youth Employment Services of Thunder Bay, Haven House of Thunder Bay (a youth shelter), the project coordinator’s contacts in the club scene, as well as the Children’s Aids Society Youth Outreach Worker’s contacts. Seven individuals applied for the position.

Interviews were conducted by a panel of three individuals representing the TBDHU, SPHRP and the Drug Strategy Initiative. Hiring was based upon a ranking system. The successful candidates had a diversity of connections with the intended target population, the ability to work in a diverse environment and were flexible and client focused. They also were required to be approachable and to demonstrate the ability to work unsupervised.

Five individuals (two female and three males) were hired for the positions of Peer Outreach Worker for a two and a half month contract. Several members of the team had strong connections to the Native youth gangs. Two outreach workers were either current or past injection drug users (IDUs). Two outreach workers were long-time homeless youth. Several of the outreach workers were able to access the bi-sexual community.

The peer outreach workers were required to work for 15 hours per week conducting surveys. All of the peer outreach workers were excited and invested in the project and volunteered much more of their time by administering questionnaires on their own time. Additionally, the outreach workers were required to keep a journal of their thoughts, feelings, and experiences while doing the surveys. This was done to evaluate the stressors the peers faced as well to communicate to the researchers the experiences that they encountered.

Training of the peer outreach workers was provided through an extensive one-evening orientation session with the developers of the questionnaire, as well as weekly meetings with the project coordinator. On going educational sessions were done by the SPHRP. Topics covered in the orientation evening included review and application of the questionnaire, intended target population, safety protocols and procedures, introduction to SPHRP front line staff, appropriate boundaries, limitations of their role, as well as appropriate use of supervision. The peer outreach workers were advised that they were not to use drugs while administering surveys. All the outreach workers agreed to adhere to the policy.

The weekly meetings with the project coordinator provided additional information on the target population, the selection and brainstorming of access points to the target population, support and debriefing of the peer outreach workers and the arrangement of peer outreach partners if necessary.

The questionnaire developers attended the second weekly peer outreach worker meeting to review the completed questionnaires, to provide further clarification on the intended target population and to answer any questions or concerns the peer outreach workers had on the application of the questionnaire. Data from the completed questionnaires were reviewed mid-way through data collection.

The Questionnaire

The Thunder Bay Drug Use Questionnaire (TBDHUQ, Appendix A) was developed to collect data on drug use prevalence among street-involved and at-risk youth aged 24 years and under as well as information on their perceptions of health care programs and service delivery. This is based on anecdotal and statistical information gathered by SPHRP staff and consultation with community agencies.

The questionnaire was developed through a collaborative effort of the program coordinator and senior outreach worker of SPHRP, Thunder Bay District Health Unit's epidemiologist, the project coordinator of the Thunder Bay Drug Use Questionnaire, and the project consultants. Several drafts of the questionnaire were written to ensure understanding and ease of administration and completion. The questionnaire was focus tested with volunteer youth at Haven House, a Salvation Army youth shelter in Thunder Bay. They provided recommendations to improve the questionnaire. Their recommendations were incorporated into the final draft.

Process

During their initial weekly meeting the project coordinator and the five outreach workers developed an outreach plan to determine how and where to target the intended population. The outreach workers and the project coordinator conducted questionnaires independently or in pairs when necessary for safety purposes. Data collection occurred over a 10 week period from January to April 2005, during the region's winter months where temperatures were well below 0°C with many days being - 40°C with wind chill.

The peer outreach workers determined whether an individual met the criteria of the intended target population for the questionnaire. If the individual met the criteria they were informed of the purpose of the Drug Use Questionnaire and asked if they had previously completed a questionnaire. If the individual had not completed a questionnaire previously they were asked whether they would like to complete one. The individual was advised that the incentive was not dependent on the completion of the questionnaire. The incentive was of a free sandwich coupon.

The individual was requested to review the questionnaire, the purpose of the questionnaire and the confidentiality statements. The individual was asked to sign the confidentiality statement (Appendix A). The questionnaire was completed using an interview format with the peer outreach worker reading the questions and recording the responses. In some instances the questionnaire was completed by the individual in the presence of the peer outreach workers. The outreach workers provided clarification to questions when necessary.

Although Thunder Bay was the primary city where data was collected, the project's coordinator as well as two peer outreach workers had the opportunity to join Superior Points Harm Reduction Program's 'North Shore HIV and Infectious Disease Road Show'. During this time the peer outreach workers and the project's coordinator administered questionnaires which were incorporated into the final analysis.

Data Analysis

Data was entered by the project coordinator along with additional assistance of one staff member of SPHRP into a Microsoft Access Database. The database was then thoroughly reviewed by one of the project consultants/authors and analyzed for accuracy.

Three hundred and thirteen questionnaires were completed within the District of Thunder Bay. The majority of the questionnaires were completed in the City of Thunder Bay (n = 276). Questionnaires were also completed in Terrace Bay (n = 16); Marathon (n = 16); and Pic River (n = 5) during the SPHRP road show. Data from these questionnaires were incorporated into all analyses. Data from five individuals who indicated that they had not used drugs during the previous 12 months were also included in all analyses.

The drugs were categorized into the seven standard categories as listed on the RCMP website (http://www.rcmp-grc.gc.ca/bc/crops/drug_awareness/drug_information/categories_e.htm) not including the steroid category. Analysis of the data included frequencies, cross-tabulations and multiple response sets (summations of multiple response data). All data analyses were conducted using SPSS.

Peer Outreach Worker Journals

The peer outreach workers were required to keep journals of their thoughts, feelings and experiences while administering surveys. Some outreach workers also recorded in their

journals during their off time. The purpose of the required journals was to evaluate the peer outreach worker's stressors during data collection and to capture the peer outreach workers' experiences for the researchers.

The peer outreach workers' journals were collected by the project coordinator during weekly meetings, photocopied, and returned to the outreach workers. Photocopies of the journals were then reviewed by the project coordinator and SPHRP's program coordinator. When outreach worker's journal entries indicated the individual experienced stressors, the project coordinator and SPHRP's program manger provided debriefing and support. Peer outreach workers kept open communication with the program coordinator regarding their experiences. The project's coordinator provided debriefing when necessary as well as when recommended by SPHRP's program coordinator.

The peer outreach worker's journals were reviewed by the project coordinator and SPHRP's program coordinator who collected quotations (Appendix B) which were also inserted throughout the final paper. The project's consultants and authors of this paper did not review the peer outreach worker journals due to time constraints of the project. Future research should include a qualitative evaluation of peer outreach worker's journals.

Limitations of the Study

Several limitations to the study exist. The employment of a purposive or judgmental sampling strategy utilizing experts (the peer outreach workers), who had connections and accessibility to the project's intended difficult to reach target population, allowed the peer outreach workers to define the sample as they decided whether individuals met criteria for the intended target population. Consequently, the sample may be limited and non-representative of the intended target population. Furthermore, the peer outreach workers may have determined that an individual did not meet the criteria of the intended target population when actually the individual did. Mechanisms were put in place to decrease the possibility of this occurring.

Education on the intended target population was provided during the one-evening educational session, ongoing education during the weekly meetings with the project coordinator, as well as extra education with the project coordinator or the program coordinator of SPHRP. Additionally, the developers of the questionnaire attended the peer outreach worker's second weekly meeting, reviewed the completed questionnaires to check whether the peer outreach workers targeted the intended population, provided further clarification on the intended target population and answering any questions or concerns the peer outreach workers had regarding application of the questionnaire. Furthermore, data was again reviewed half way through data collection by the developers of the questionnaire which resulted in preliminary demographic data appearing to reflect the intended target population.

Although the peer outreach workers were advised to not conduct surveys with individuals that were intoxicated or under the influence of substances, the outreach workers determined whether or not to conduct the surveys. They had no formal training in

assessment of intoxication or mental status examination training. Consequently, some questionnaires may have been completed with intoxicated individuals and their responses may not be factual.

It is unknown whether multiple questionnaires were completed by one respondent as an 'honor system' was used

.
Data was collected during the winter season when temperatures typically fall below -30°C. It was expected that homeless individuals would not be residing outside but would have secured some type of housing. Consequently, data collected is season and climate specific and may not reflect the drug use habits of street-involved and at-risk youth less than 24 years of age, in Thunder Bay District during the warmer months.

Results

“Thunder Bay is infested with druggies who need help and it was great being able to do my part.” Peer Outreach Worker

Data collection captured the individual’s (1) demographics; (2) drugs used; (3) sharing of works (previous and current); (4) access and use of condoms when sexually active; (5) accessibility to the health care system; (6) community development; as well as (7) any comments or information participants thought was important to include.

(1) Demographics

Three hundred and thirteen individuals completed the questionnaires which exceeded the project’s projection of 300. Questionnaires were administered in the City of Thunder Bay (n = 276), as well as communities within the District of Thunder Bay which included: Terrace Bay (n = 16); Marathon (n = 16); and Pic River (n = 5). Over 95% (n = 299) of the sample population were less than 25 years of age. Eleven individuals (male = 9, female = 2) were 25 years of age or older, 238 individuals (134 males and 99 females) were between the ages of 16 and 24 years of age, and 61 individuals (23 males and 38 females) were less than 16 years of age.

The division of gender was 53.4% male (n = 167) and 44.7% female (n = 140) with six individuals not reporting. Ethnicity of this sample consisted of 42.8% (n = 134) Native Canadian and 53.7% (n = 168) non-native Canadian with 11 individuals not reporting their ethnicity.

The majority of the participants (62%; n = 194,) resided in either a house or apartment. Ninety individuals indicated that they were homeless, either ‘couch surfing’ (21.4%) or residing at a shelter (7.3%). Although 13 individuals indicated that their living situation was not captured by the questionnaire, only one person provided further elaboration and signified that they were living on the “street’. Eleven individuals (4.2%) did not comment on their current living situation.

It is unknown whether the individuals who resided in a house or apartment financially contributed to their situation. It was expected that no individuals would have reported they ‘lived on the streets’ as data collection occurred over the winter months where temperatures were well below 0°C reaching -40 °C with wind chill.

Table 1.**Demographics and Drug Use**

		Percentage	Count
Age	16 years of age or under	19.5	61
	17 - 24 years of age	76.0	238
	25 years of age or older	3.5	11
	Did not report	1.0	3
	Total	100.0	313
Gender	Male	53.4	167
	Female	44.7	140
	Did not report	1.9	6
	Total	100.0	313
Ethnicity	Native Canadian	42.8	134
	Other	53.7	168
	Did not report	3.5	11
	Total	100.0	313
Living Situation	House/apartment	62.0	194
	Couch Surfing	21.4	67
	Shelter	7.3	23
	Other	5.1	16
	Did not report	4.2	13
	Total	100.0	313
Drug use during previous 12 months	Reported use of drugs	98.4	308
	Reported no use of drugs	1.6	5
	Total	100.0	313
Participant knows an IDU	Does know an IDU	70.9	222
	Does not know an IDU	27.8	87
	Did not report	1.3	4
	Total	100.0	313
History of injecting	Has injected	30.4	95
	Never injected	65.2	204
	Did not report	4.5	14
	Total	100.0	313

Table 2.**Injection Drug Use by Age and Gender**

Gender	Age			Did not report	Total
	16 years of age or under	17 - 24 years of age	25 years of age or older		
Male	5	48	4	0	57
Female	2	30	1	1	34
Did not report	0	3	0	1	4
Total	7	81	5	2	95

Table 3.**Cross-tabulation of Status of Previous Injection Drug Use and Knowledge of an Injection Drug User.**

Knowledge of an IDU	Status of Previous Injection Drug Use			Total
	History of Injecting	Never injected	Did not report on Injection Behavior	
Individual knows an IDU	95	120	7	222
Individual does not know an IDU	0	81	6	87
Did not Report	0	3	1	4
Total	95	204	14	313

Three hundred and eight individuals (98.4%) reported drug use over the previous 12 months (Table 1). Table 2 highlights injection drug use (IDU) by age and gender while table 3 shows a cross-tabulation of status of previous injection drug use and knowledge of an injection drug user.

Injection drug use was reported by 95 individuals (male = 57; females = 34) of which seven individuals (male = 5, female = 2) were less than 16 years of age (Table 2). Two hundred and twenty two individuals (70.9%) indicated that they knew an injection drug user (Table 3). Although 204 individuals (65.2%) indicated that they had never injected, 120 of these individuals (58.82%) know someone who does inject (Table 3). Ethnicity of individuals who had a history of injection drug use was similar (43 Native Canadians and 48 Non-native Canadians).

(2) Drugs Used

Data was collected on drugs of choice and drugs of convenience including frequency of use and routes of administration of these drugs. Data was collected in four instances where individuals listed multiple drugs of choice. In these instances the first drug listed was incorporated into the analysis. Data was also collected on participant's reasons for

using a convenience drug and not their drug of choice. Participants reported on all the drugs which they used over the previous six months.

(a) Drugs of Choice

Over 97% (n = 304) of the sample provided information regarding their drug of choice. Only nine individuals (2.90%) did not report this information. The drug categories of the choice drugs can be seen in Table 4. Central Nervous System (CNS) stimulants (36.84%; n = 112) were the most frequently identified drug of choice, with Cannabis (28.29%; n = 86) being the second most frequent category. CNS depressants (n = 7; 2.30%) and Phencyclidines (n = 1; 0.003%) were the least frequently cited category of choice drug. None of the sample indicated the drug category of Inhalants as a drug of choice.

Table 4.

Drugs of Choice by Drug Category

<u>Drug Category</u>	<u>n</u>	<u>%</u>
CNS Stimulants	112	36.84
Cannabis	86	28.29
Narcotic Analgesics	57	18.75
Hallucinogens	37	12.17
CNS depressants	7	2.30
Phencyclidine	1	0.003
Inhalants	0	0
Other	4	1.32
Total	304	

The frequency of drugs of choice with routes of administration is identified in Table 5. CNS stimulants comprised 38.03% (n = 108) of the top 10 choice drugs, followed by Narcotics (19.01%; n = 54), Cannabis (29.57%; n = 84), Hallucinogens (11.27%; n = 32) and CNS depressants (2.11%; n = 6).

Cocaine (26.8%; n = 84) and Marijuana (26.8%; n = 84) were the most frequently cited drugs of choice. All other drugs were used by less than 10% of the sample. Together both drugs accounted for 53.64% of the sample. Oxy Contin (n = 23; 7.3%), Ecstasy (n = 19; 6.1%) and Magic Mushrooms (n = 13; 4.2%) rounded up the top five drugs of choice.

Prescription drugs were reported by 15.55% (n = 49) of individuals as their drugs of choice, which included predominantly Narcotics (Oxy Contin, Morphine, Percocet, and Codeine). Three individuals indicated Ritalin and one individual indicated Xanax as their drugs of choice. Two individuals reported their drugs of choice were “pills” without any further elaboration. One individual indicated an ‘over the counter’ medication (Dextromethorphan) as their drug of choice.

Ritalin was cited as a drug of choice less than anticipated, particularly when CNS stimulants were the most frequently cited category for choice drugs. There may be a bias with youth as some individuals questioned may have a prescription for it. Alcohol as a

drug of choice was less than anticipated particularly since it is easily accessible and is 'acceptable'. The sample may not perceive alcohol as a drug or the peer outreach workers only approached traditional drug users.

Table 5.

Drugs of Choice with Routes of Administration

Drug	N		Route of Administration											
			Inject		Snort		Smoke		Swallow		Insert		Patch	
			n	%	n	%	n	%	N	%	n	%	n	%
Cocaine	84	26.8	32	17.3	75	40.54	69	37.3	9	4.86	0	0	0	0
Marijuana	84	26.8	0	0	2	2.22	84	93.3	4	4.44	0	0	0	0
Oxy Contin	23	7.3	4	12.5	22	68.75	0	0	6	18.8	0	0	0	0
Ecstasy	19	6.1	0	0	15	41.67	1	2.78	18	50.0	1	2.78	1	2.78
Magic Mushrooms	13	4.2	0	0	1	6.67	1	6.67	13	86.7	0	0	0	0
Methamphetamine	13	4.2	1	3.7	9	33.33	13	48.2	4	14.8	0	0	0	0
Morphine	12	3.8	10	50.0	4	20.0	0	0	3	15.0	1	5	2	10.0
Crack	11	3.5	3	13.0	6	26.08	10	43.5	4	17.4	0	0	0	0
Heroin	11	3.5	10	55.6	3	16.67	4	22.2	1	5.56	0	0	0	0
Percocet	8	2.6	0	0	7	53.85	1	7.69	5	38.5	0	0	0	0
Alcohol	6	1.9	0	0	0	0	0	0	6	100.0	0	0	0	0
LSD	5	1.6	0	0	0	0	0	0	5	100.0	0	0	0	0
Ritalin	3	1	3	50.0	2	33.33	0	0	1	16.7	0	0	0	0
Codeine	2	0.6	0	0	2	40.0	2	40.0	1	20.0	0	0	0	0
Oil	2	0.6	0	0	0	0	2	100.0	0	0	0	0	0	0
"Pills"	2	0.6	0	0	2	33.33	1	16.7	1	16.7	2	33.3	0	0
"All Drugs"	1	0.3	1	20.0	1	20.0	1	20.0	1	20.0	1	20.0	0	0
Dextromethorphan	1	0.3	0	0	1	0	1	33.3	1	33.3	0	33.3	0	0
Herbal Hallucinogenic	1	0.3	0	0	0	0	1	100.0	0	0	0	0	0	0
"Nothing"	1	0.3	0	0	0	0	0	0	0	0	0	0	0	0
PCP	1	0.3	0	0	0	0	1	100.0	0	0	0	0	0	0
Xanax	1	0.3	0	0	1	50.0	0	0	1	50.0	0	0	0	0
Did not report	9	2.9	0	0	0	0	0	0	0	0	0	0	0	0
Total	313		64		153		192		84		5		3	

The routes of administration for the drugs of choice are identified in Table 5. The participants of the questionnaire were requested to indicate all the routes of administration of their drug of choice, consequently multiple routes of administration were reported for the participant's drug of choice.

The majority of individuals (53.4%; n = 167) used one route of administration for their drug of choice, however 43.4% (n = 136) reported multiple routes of administration, these included: two routes (3.1%; n = 41); three routes (2.9%; n = 4); four routes (2.9%; n = 9); and five routes (0.3%; n = 1). Ten individuals did not report their route of administration for their drug of choice.

The most frequent route of administration for choice drugs was smoking which was identified by 38.32% (n = 192). The remaining rank ordered choice drugs routes of administration included: snorting (30.34%); swallowing (16.77%); injecting (9.89%); insertion (1%); and transdermal patch (0.6%).

Injection was reported for 9.89% of choice drugs which included: Cocaine (50%); Heroin (15.62%); Morphine (15.62%); Crack (4.69%); OxyContin (6.25%); Ritalin (4.69%); and Methamphetamines (1.56%).

Injection only occurred for both CNS stimulants (n = 39) and Narcotics (n = 24), although one individual also indicated they inject their choice drug being 'all drugs.' Smoking (38.17%, n = 92) and snorting (38.17%, n = 92) were the most frequently reported routes of administration for CNS stimulants. Injection was reported for 16.18% (n = 39) of CNS stimulants with swallowing occurring in 18 instances (7.47%). The administration routes used for Narcotics, included: snorting (42.86%; n = 39); injection (26.37%; n = 24); swallowing (18.68%; n = 17); smoking (8.79%; n = 8); transdermal patch (2.20%; n = 2); as well as insertion (1.10%, n = 1).

The frequency of individuals who snort (n = 75) and smoke cocaine (n = 69) was similar. Additionally, cocaine was injected by 17.3% of cocaine users and was swallowed in nine instances.

The routes of administration of Methamphetamines included snorting and smoking by 9 and 13 individuals respectively. Only one individual reported injection of methamphetamines. Methamphetamines are new to Thunder Bay.

(b) Drugs of Convenience

The frequency of drugs of convenience by drug category is identified Table 6. The most frequently indicated convenience drug category was Cannabis cited by 46.64% of the sample. The remainder of convenience drug categories included CNS stimulants (24.50%), Narcotic Analgesics (18.12%) and CNS Depressants (6.04%). None of the sample reported use of Inhalants or Phencyclidine. ‘Other drugs’ were reported by eight individuals included ‘pills’ (n = 5), ‘all drugs’ (n = 2) and herbal hallucinogens (n = 1).

Table 6. Drugs of Convenience by Drug Category

<u>Drug Category</u>	<u>n</u>	<u>%</u>
Cannabis	139	46.64
CNS Stimulants	73	24.50
Narcotic Analgesics	54	18.12
CNS depressants	18	6.04
Hallucinogens	6	2.01
Phencyclidine	0	0
Inhalants	0	0
Other	8	2.68
Total	298	

The drugs of convenience and routes of administration are identified in Table 7. Marijuana was the predominant drug of convenience, cited by over 44% of individuals. Every other convenience drug was used by less than 10% of the sample.

Prescription and pharmaceutical pills/medication comprised 25.24% (n = 79) of the convenience drugs with most frequently being Narcotics (68.35%, n = 54), followed by CNS stimulants (25.31%; n = 20), and “pills” which were not further elaborated on (0.001%; n = 5).

Methamphetamines (9.9%, n = 31), Ritalin (6.4%, n = 20), Alcohol (5.8%, n = 18), Percocet (5.8%, n = 18), and Codeine (1.9%, n = 6) had an increased frequency of use as a convenience drug compared to drug of choice.

Table 7. Drugs of Convenience with Routes of Administration

			Route of Administration											
			Inject		Snort		Smoke		Swallow		Insert		Patch	
Drug	N	%	n	%	n	%	n	%	n	%	n	%	n	%
Marijuana	138	44.1	0	0	3	2.07	137	94.48	5	3.45	0	0	0	0
Methamphetamine	31	9.9	9	13.43	26	38.81	30	44.78	2	2.99	0	0	0	0
Ritalin	20	6.4	17	36.17	15	31.91	8	17.02	7	14.89	0	0	0	0
Alcohol	18	5.8	0	0	0	0	0	0	18	100.0	0	0	0	0
Percocet	18	5.8	0	0	17	73.91	1	4.35	5	21.74	0	0	0	0
Cocaine	17	5.4	8	22.86	15	42.86	11	31.43	1	2.86	0	0	0	0
Morphine	16	5.1	12	54.54	6	27.27	0	0	2	9.09	1	4.54	1	4.54
Oxy Contin	14	4.5	4	20.0	11	55.0	0	0	5	25.0	0	0	0	0
Codeine	6	1.9	0	0	4	57.14	1	14.29	2	28.57	0	0	0	0
“Pills”	5	1.6	1	10.0	5	50.0	2	20.0	2	20.0	0	0	0	0
Crack	3	1.0	0	0	0	0	3	100.0	0	0	0	0	0	0
Ecstasy	3	1.0	0	0	1	16.67	2	33.33	3	50.0	0	0	0	0
Magic Mushrooms	3	1.0	0	0	0	0	0	0	3	100.0	0	0	0	0
“All Drugs”	2	0.6	1	12.5	2	25.0	2	25.0	2	25.0	1	12.5	0	0
Tobacco	2	0.6	0	0	0	0	2	100.0	0	0	0	0	0	0
Herbal Hallucinogenic	1	0.3	0	0	0	0	1	100.0	0	0	0	0	0	0
Oil	1	0.3	0	0	0	0	1	100.0	0	0	0	0	0	0
Did not Report	15	4.8	0	0	0	0	0	0	0	0	0	0	0	0
Total	313		52		105		201		57		2		1	

The majority of respondents (69%; n = 216) reported a single administration route for their drug of convenience, while 25.6% (n = 80) listed multiple routes of administration. Specifically, 50 individuals reported two routes of administration, 24 individuals reported three routes, 6 individuals reported four routes and one individual reported using five routes. Sixteen individuals did not report their route of administration of their convenience drug.

Smoking (48.09%) was the most frequently cited route of administration followed by snorting (25.12%) and swallowing (13.64%). Injection was reported by 12.44% (n = 52) of convenience drugs. CNS stimulants (65.38%; n = 34) was the most frequently drug category for injection, followed by CNS depressants (30.76%; n = 16) with “pills” 1.92%; n = 1) and “all drugs” (1.92%; n = 1). Injected drugs included: Ritalin (32.69%; n = 17); Morphine (23.08%; n = 12), Methamphetamines (17.31%; n = 9), Cocaine (15.38%; n = 8), and Oxy Contin (7.70%; n = 4).

Injection has increased with the use of Methamphetamines (n = 9), Morphine (n = 12) and “pills” (n = 1) as convenience drugs contrasted with drugs of choice, however injection of Cocaine has decreased.

Insertion and patches were reported as a route of administration for one individual with Morphine as the drug of convenience. One individual also indicated insertion for “all drugs”.

Methamphetamines were cited as both a drug of choice and convenience for seven individuals. Twenty four individuals indicated it was their convenience drug when their drug of choice was Cocaine (n = 20), Heroin (n = 2), Marijuana (n = 1) and Crack (n = 1). Six individuals who indicated that Methamphetamines were their choice drug reported their convenience drugs were Marijuana (n = 3), Ritalin (n = 1), Crack (n = 1), and “pills” (n = 1).

There appears to be a consistency amongst IDU's. Forty-seven individuals (28 males, 18 females, 1 no gender reported) indicated injection as a route of administration for both their drugs of choice and convenience, two of which were less than 16 years of age. Ethnicity was similar for this population with 20 Native Canadians and 23 non-native Canadians. Four individuals did not report their ethnicity.

(c) Differences between Drugs of Choice and Convenience

The participants were requested to indicate all reasons for differences between their choice and convenience drugs, by category, as well as list their reason when the category “Other” was utilized. Reasons for differences between drugs of choice and convenience are identified in Table 8.

Table 8. Reasons for Differences between Drugs of Choice and Convenience

	Frequency	Percent
No Differences between Choice and Convenience Drugs	75	24.0
Did not report Differences	21	6.7
Differences between Choice and Convenience Drugs	217	69.3
<u>Reasons for Differences</u>		
Financial	148	45.7
Access problems	87	26.2
No place to use	8	2.6
Do not have assistance to use	3	1.0
Problems accessing works	2	.6
Do not have required works	1	.3
Other	46	14.7
Choice	8	
Better/different “high” with drug of convenience	4	
Health risks	1	
Withdrawal effects of choice drug	1	
“Addicted” to drug of convenience	1	
‘Relieve high” of choice drug	1	
High of choice drug causes problems	1	
Only use choice drug with certain individuals	1	
None one to do choice drug with	1	
‘Attempting to quit’ choice drug	1	
Location of choice drug use – “cannot drink at work”	1	
Time – “to busy”	1	

Two hundred and thirteen individuals (68.05%) reported differences between their drug of choice and drug of convenience while 24% (n = 75) indicated their drug of choice was also their drug of convenience.

Financial reasons (n = 145) were the most frequently reported reason for using a convenience drug followed by difficulties with accessing their drug of choice (n = 87). Eight individuals indicated that there was no place to use their choice drugs. In this instance choice drugs were Ecstasy (n = 2), Methamphetamines (n = 2) with Crack, Heroin, Marijuana and Oxy Contin was listed by one individual each. Drugs of convenience for these individuals were Ritalin (n = 3); Marijuana (n = 3); Methamphetamines (n = 1) and Alcohol (n = 1). Four individuals indicated they inject their drug of choice and three individuals inject their drug of convenience.

Three individuals reported using a drug of convenience because they did not have assistance with using their choice drug. The drugs of choice for these individuals were Cocaine, Crack and Heroin, with injection being one of each individual's multiple listed routes of administration. Two of these individuals reported that they inject their drug of convenience.

Two individuals reported convenience drug use because of difficulties accessing required works for their drugs of choice which were Oxy Contin (n = 1) and Cocaine (n = 1). The individual who used Oxy Contin injected it, as well as listed injection as one of the routes for their drug of convenience.

One individual indicated they did not have the required works for their drug of choice. In this instance their drug of choice was Oxy Contin and their convenience drug was Ritalin. This individual listed injection as one of the routes of administration for both their drug of choice and convenience.

The most frequently cited "Other reasons" for using a drug of convenience was choice of using a convenience drug (n = 8). Additional reasons for convenience drug included: experienced a different/better "high" with the convenience drug (n = 4); to relieve the high of the choice drug (n = 1); withdrawal effects of choice drug (n = 1); difficulties experienced because of high of choice drug (n = 1); and addicted to convenience drug (n = 1). One individual indicated use of choice drug with certain individuals while one individual reported no one to use their choice drug with. One individual reported that they were unable to use their choice drug, which was alcohol, at work. Only one individual reported their use of a convenience drug because they were attempting to quit their drug of choice. One individual identified that they used their convenience drug for health reasons, "I understand that if I do it too much it will kill me."

(d) Drugs Used During the Previous Six Months

Participants were requested to report on all of the drugs they have used during the previous six months. Table 9 identifies the frequency of drugs participants used by drug category while table 10 identifies the drugs used by participants during the previous six months. Multi-response sets were incorporated as individuals were able to list multiple responses; consequently the total number of responses equals 1500.

Table 9.

Drugs used During the Previous Six Months by Drug Category (Multi-response Set)

<u>Drug Category</u>	<u>n</u>	<u>%</u>
CNS Stimulants	423	28.20
Cannabis	350	23.33
Narcotic Analgesics	343	22.87
Hallucinogens	218	14.53
CNS depressants	120	8.00
Phencyclidine	7	0.5
Inhalants	0	0
Other	46	3.07
Total	1500	

Table 10.

Frequency of Drugs used During the Previous Six Months (Multi-response Set)

Drug	Frequency	Percent
Marijuana	265	17.70%
Cocaine	198	13.20%
Oxy Contin	112	7.50%
Magic Mushrooms	102	6.80%
Percocet	94	6.30%
Methamphetamine	79	5.30%
Crack	68	4.50%
Ecstasy	67	4.50%
Alcohol	64	4.30%
Morphine	64	4.30%
Ritalin	63	4.20%
Oil	43	2.90%
Hash	42	2.80%
LSD	35	2.30%
Valium	33	2.20%
Codeine	31	2.10%
“Pills”	26	1.70%
Heroin	24	1.60%
Sedative	11	0.70%
Herbal Hallucinogenic	9	0.60%
PCP	7	0.50%
Tobacco	7	0.50%
Fentanyl	6	0.40%
Amphetamine	5	0.30%
GHB	5	0.30%
“All Drugs”	4	0.30%
Dextromethorphan	4	0.30%
MDMA	4	0.30%
Prozac	4	0.30%
CPZ	3	0.20%
Dilaudid	3	0.20%
Dexedrine	2	0.10%
Ketamine	2	0.10%
Opium	2	0.10%
Absinthe	1	0.10%
Caffeine	1	0.10%
Gravol	1	0.10%
Methadone	1	0.10%
Morning Glory	1	0.10%
Mouthwash	1	0.10%
Patch	1	0.10%
Quaalude	1	0.10%
Resperidol	1	0.10%
Seroquel	1	0.10%
Tallwin	1	0.10%
Xanax	1	0.10%
Total	1500	

Central nervous system stimulants (28.20%) were the most frequently cited category of drug used by individuals during the previous six months, followed by Cannabis (23.33%), Narcotics (22.87%), Hallucinogens (14.53%), CNS depressants (8.0%) and Phencyclidines (0.5%). None of the sample indicated use of Inhalants. Forty six individuals listed drugs that were not captured by the traditional drug categories (see Table 10 for further details).

Marijuana (17.70%, n = 265) and Cocaine (13.20%, n = 198) were the most frequently reported drugs used by individuals during the previous six months followed by Oxy Contin (7.50%, n = 112), Magic Mushrooms (6.80%; n = 102), Percocet (6.30%; n = 94), and Methamphetamines (5.30%, n = 79). All other drugs were each used by less than 5% of the population.

Pharmaceutical pills or medication, either prescription or non-prescription represented 31.40% (n = 471) of all reported drugs used over the previous six months. The majority (66.45%; n = 313) were Narcotics, however 15.71% (n = 74) were CNS stimulants, while 10.40% (n = 49) were CNS depressants, 0.006% (n = 3) hallucinogens, 5.52% (n = 26) were “pills”, and 0.004% (n = 2) were anti-psychotics.

(3) Shared Works (Previous and Current)

Table 11. Access and Use of Clean Works

	Frequency	Percent
Clean works accessed and used	148	47.3
Clean works never accessed and used	139	44.4
Did not report	26	8.3
Total	313	100.0

Works has been defined for the purpose of this study as any paraphernalia that may contain blood or a transmittable virus. Clean works, works that does not contain blood or transmittable viruses, have been accessed and used by 47.3% (n = 148) of the participants, while 44.4% (n = 139) have never accessed or used clean works (Table 11).

Table 12. Current and Previous Sharing of Works

Sharing of Works	Frequency	Percent
Currently shares works	192	61.3
Previously shared works	234	74.8
Total	426	

Table 13. Cross-tabulation of Current and Previous Sharing of Works

Current Sharing of Works				
Previously Shared Works	Currently Shares Works	Does Not Share Works	Did Not Report	Total
Previously Shared Works	187	39	8	234
Never Shared Works	4	38	15	57
Did Not Report	1	3	18	22
Total	192	80	41	313

Table 14.**Sharing of Works (Current and Previous) vs. Accessing and Use of Clean Works**

Access and Use of Clean Works	Previously Shared Works	Currently Shares Works	Total
Accessed and used clean supplies	130	100	230
Never accessed or used clean supplies	102	89	191
Did not report	2	3	5
Total	234	192	426

A total of 426 individuals either currently (61.3%; n = 192) or previously shared (74.8%; n = 234) works while using drugs (Table 12). Table 13 illustrates a cross tabulation of previous and current sharing of works by participants. One hundred and eighty-seven individuals who indicated sharing of works previously also indicated current sharing of works. Thirty nine individuals who reported previous sharing of works signified that they do not share works currently. Thirty eight (38) individuals who did not previously share works reported that they were currently sharing works. Table 14 highlights the current and previous sharing of works by the access and use of clean supplies. One hundred and ninety one individuals (44.83%) which either previously or currently shares works had never accessed or used clean supplies.

Table 15. Shared Works (Current and Previous) by Route of Administration (Multi-response Set)

Works	Frequency	Percent
Snorting Equipment	280	48.3%
Smoking Equipment	200	34.5%
Injecting Equipment	96	16.6%
Patch	2	0.3%
Drinking Equipment	1	0.2%
"All Equipment"	1	0.2%
Total	580	100.0%

Individuals were requested to list all previously and currently shared works. Table 15 shows the frequency of shared works (current and previous) by route of administration. The majority of individuals indicated they have shared either two (21.4%, n = 67) or three works (21.7%; n = 68). Forty nine individuals (15.7%) reported sharing one works. Thirty individuals (9.6%) reported sharing four works. Fourteen individuals (4.5%) reported sharing five works. Eighty five individuals (27.2%) did not report on shared works.

Snorting equipment was the most frequently cited shared works (currently or previously) by individuals (48.3%; n = 280). Specifically, the shared equipment consisted of surfaces (n = 4) and lines (n = 2) with the remainder of snorting equipment consisting of bills, straws, and pens.

Smoking equipment was shared in 200 instances. Smoking equipment consisted of pipes (n = 164), joints (n = 74), bongos (n = 13), marijuana/oil (n = 4), papers (n = 2). Injecting equipment was reported to be shared in 95 instances. Specifically, shared injecting equipment included: needles (n = 63), ties (n = 17), spoons (n = 11) and water (n = 4). Drinking equipment was shared two instances. Both consisted of sharing glasses. Patches were reported to being shared on 2 instances. Inserts and 'all equipment' were cited to be shared on one instance each.

Table 16. Frequency of Pipe Sharing

Sharing of Pipes	Frequency	Percent
Shares Pipe	214	68.4
Does Not Share Pipe	36	11.5
Did Not Report	63	20.1
Total	313	100.0

The majority of the participants (68.4%) indicated that they share a pipe when they smoke crack or other drugs, while 11.5% responded that do not share. (Table 16). The frequency of pipe sharing was more prevalent when the participants were asked specifically about this behavior as compared to the frequency of reported pipe sharing when the participants were asked generally about the works they have shared.

Table 17. Reasons for Current and Previous Sharing of Works

Reasons for works being shared	Frequency of Currently Sharing	Frequency of Previously Shared	Total
Cost	59	53	112
Inconvenient to use clean works	73	64	137
Problems accessing clean works	58	48	106
Difficulty using works properly/safely	26	14	40
Others share works and afraid to ask for clean works	61	52	113
Other reason	60	37	97
Don't care	12	14	36
Didn't know of risk	4	10	14
Only share with trusted persons	6	15	21
Cost of new/clean works, got it free	1	1	2
What I do is not a problem (bills)	0	3	3
You have to share a joint	5	4	9
No choice	2	3	5
Convenience	2	7	9
Reply unrelated to question	0	5	5

The samples reasons for previous and current sharing of works are illustrated in Table 17. Overall there was an increase across all categories of reasons for currently sharing works compared to previously sharing of works except for 'other reasons' which has decreased.

The most frequent cited reason individuals reported for currently sharing of works was that it was inconvenient to use clean works ($n = 73$), followed by others shared works with them and the individual was afraid to ask for clean works ($n = 61$). Cost and problems accessing clean works was reported by 59 and 58 individuals respectively. Twenty six individuals reported that they shared works currently because the individual had difficulty using works properly and safely alone. Although 60 respondents reported 'other' reasons for current sharing works only 32 individuals listed their reason, with the most frequent reason being "don't care" ($n = 12$).

The most frequently cited reasons for previously sharing works included the inconvenience to use clean works ($n = 64$), cost of clean works ($n = 53$), and the individual was afraid to request clean works when others were sharing with them ($n = 52$). Although 37 respondents indicated other reasons for previously shared works, 62 individuals listed the other reason specifically with the most frequent reasons being the individual only shares with people they trust ($n = 15$), 'do not care' ($n = 14$) and did not know risks involved with sharing of works ($n = 10$).

(4) **Access and Use of Condoms when Sexually Active****Table 18. Frequency of Condom Use when Sexually Active**

Condom Use	Frequency	Percent
Always uses a condom	85	27.2
Frequently uses a condom	59	18.8
Sometimes uses a condom	77	24.6
Rarely uses a condom	30	9.6
Never uses a condom	34	10.9
Did not report condom use	28	8.9
Reasons for not using a condom	157	
Monogamous, trust partner	47	
Don't like the feel; hurts	27	
Don't/didn't have any	29	
On the pill, other re birth control	6	
Don't/didn't care	3	
Really drunk, messed up	15	
Lesbian	2	
Not having sex	7	
Having a baby	3	
Expensive, unavailable	3	
Don't know	2	
Meaning of response unclear	3	

Table 19. Access to Free Condoms

Access to Free Condoms	Frequency	Percent
Does Access Free Condoms	243	77.6
Difficulty/unable to Access Free Condoms	28	8.9
Did Not Report	42	13.4
Total	313	100.0

Participants were requested to indicate their frequency of condom use when sexually active on a five-point scale which ranged from 'always use a condom' to 'never use a condom,' (Table 18). Eighty-five individuals (27.2%) indicated they always use a condom when sexually active, 34 (10.9%) reported they never use a condom. Twenty-eight respondents (8.9%) did not complete the condom-use question.

One hundred forty-seven respondents listed a reason for not using a condom. The most frequent reason for not using a condom was that the individuals was in a monogamous trusting relationship (n = 47). Seven individuals indicated they were not sexually active. Fifteen participants reported they did not use a condom when sexually active because they were intoxicated and two individuals did not know if a condom was used. Twenty-

seven individuals reported they did not use a condom because they did not like the feeling when a condom was used and three individuals stated they did not care about using a condom when they became sexually active. Twenty-nine individuals stated a condom was not available during time of sexual activity. Three participants reported they do not use condoms because they are expensive to purchase.

Nine individuals indicated reasons for not using a condom centered on birth control. Of these individuals three were currently pregnant and six were currently using an alternative form of birth control.

Of the 34 individuals who reported never using a condom when sexually active, 18 were male and 15 were female. Five individuals were less than 16 years of age. Twenty five of these individuals reported they previously shared works while 17 currently share works. Twelve have a history of injecting, with 7 indicating they currently inject their choice drug and 6 currently inject their convenience drug. Fourteen have never accessed and used clean works.

The majority of the participants (77.6%) report that they access free condoms. However, 8.9% indicated that they experience difficulty or are unable to access free condoms (Table 19).

(5) **Accessibility to the Health Care System**

“A girl came into work today asking if someone here had the drug surveys. She was so nice. So helpful. She shared a story with me that gave me a sick feeling in the pit of my stomach. She had gone to one of the places for PAP test and for 3 years she was asking about little spots she had. They were dismissed as ingrown hairs. It was only recently that it was properly diagnosed as HPV.....maybe HBV. Scary f.....shit.” Peer Outreach Worker

Table 20. Accessibility to the Health Care System

		Frequency	Percent
Access of health care	Does Access Health Care	219	70.0
	Does Not Access Health Care	58	18.5
	Did Not Report	36	11.5
	Total	313	100.0
Problems accessing healthcare	Has problems accessing health care	60	19.2
	Does not have problems accessing health care	220	70.3
	Did not report	33	10.5
	Total	313	100.0
Reasons for difficulty/problems accessing healthcare	No health card or card is expired	25	41.67
	No family physician	7	11.67
	Difficulties with transportation	6	10.00
	No identification	4	6.67
	Do not like how they are treated	3	5.00
	Not able to afford prescriptions	2	3.33
	New resident , do not know where services are	2	3.33
	Other access difficulties	2	3.33
	Perceive they are over-prescribed medication	1	1.67
	Service needed is not covered by OHIP	1	1.67
	Need dental also	1	1.67
	Choice	1	1.67
	Other	5	8.33
	Total	60	

Table 21.**Cross-tabulation of Health Care Access vs. Difficulties Accessing Health Care**

		Problems Accessing Health Care			Total
		Has Problems Accessing Health Care	No Problems Accessing Health Care	Did Not Report	
Health Care Access	Individual Accesses Health Care	29	189	1	219
	Does Not Access Health Care	31	27	0	58
	Did Not Report	0	4	32	36
Total		60	220	33	313

Participants were asked whether they access the health care system, as well as any difficulties they may experience. (Table 20). The majority of the participants (70.0%) do access health care while 18.5% (n = 58) of the sample indicated they do not access health care. Problems accessing health care was experienced by 19.2% (n = 60) of the sample, of which 31 individuals (51.67%) do access health care and 29 (48.33%) do not (Table 21).

The predominant reason identified for difficulties experienced in accessing health care was due to not having a health card or an expired health card (41.67%). Four individuals (6.7%) identified not having other required identification.

Six individuals (10%) reported their difficulty with health care was due to transportation while two (3.33%) indicated that they did not know the location of services. Three individuals reported that although they access healthcare the problems that they experience is related to how they were treated by health care personnel. These individuals indicated that they were treated negatively. Two individuals stated that they do not access health care because they cannot afford any prescribed medication. One individual thought that they are over prescribed medications. One participant stated that the services they require are not covered by OHIP.

Seven participants identified that their difficulties with accessing health care is a result of not having a family physician.

(6) Community Development

Individuals were asked about their perceptions of the need for a youth specific harm reduction worker, whether they would use a drug test kit if they were available, as well as their perceptions of other needed community services and programs. Table 22 highlights participant's responses regarding community development.

The majority of participants (78%) identified that there was a need for a youth specific harm reduction worker, as well (72%) identified that they would utilize a drug test kit if available.

Fifty eight individuals indicated a need for more community programs and services (table 22). The predominant theme was improved health care services which included access and availability, education, counseling, treatment and harm reduction services.

Nine individuals indicated a need for harm reduction education. Seven of these individuals reported a need for education on drugs, specifically: abuse (n = 2); drugs and spread of infection and disease (n = 2); safe drug use (n = 1); harm reduction focused on pipes (n = 1); drug education "towards natives" (n = 1); and "more on drugs." Protected sex and community education on sexually transmitted diseases were identified by two individuals. Further harm reduction programming included safe injection sites (n = 2), a youth harm reduction worker (n = 1) and distribution of birth control (n = 1).

Eight individuals identified a need for more doctors and walk-in clinics. One person suggested that walk-in clinic times need to be reduced and another suggested doctors should be "more caring."

More addiction treatment programs and services were identified by five individuals. These included: Oxy Contin detoxification and rehabilitation (n = 2); methadone clinics (n = 1); Alcoholics and Narcotics Anonymous meetings (n = 1); and addiction services over all (n = 1).

Seven individuals indicated a need for recreational programs and activities. Specifically suggestions included after school sports, dances, places to "hang out", indoor skate parks, and drop in centers. The predominant theme was indoor activities which may be attributed to the winter season when data was collected. Three individuals signified a need for more youth safe houses/shelters. Two individuals suggested a need for more food banks.

Table 22. Community Development

		Frequency	Percent
Identified Need for a Youth Specific Harm Reduction Worker	Identified Need For a Youth Specific Harm Reduction Worker	243	77.6
	No Need for a Youth Specific Harm Reduction Worker	31	9.9
	Did Not Report	39	12.5
	Total	313	100.0
Use of Drug Test Kit if Available	Would Use a Drug Test Kit	225	71.9
	Would Not Use a Drug Test Kit	51	16.3
	Did Not Report	37	11.8
	Total	313	100.0
Other Identified Community Services and Programs that are Needed	Harm reduction education	9	
	Doctors and walk-in clinics	8	
	Recreational activities	7	
	Addictions treatment and maintenance programs	5	
	Services/programs that provide help and advice	4	
	"All services"	4	
	No more services/programs are needed	3	
	Housing/shelters	3	
	Better transit system	3	
	Safe injection sites	2	
	Police need to be more understanding	2	
	Food banks	2	
	Distribution of birth control	1	
	Youth outreach worker	1	
	"A moving drug truck"	1	
	Improved jails	1	
	Counselors (drug and family)	1	
	Legalization of Marijuana	1	
	Jobs	1	
	Other	1	
Total	58		

(7) Participant's Final Comments

Participants were requested to provide any further information that they thought was important. Fifty-seven individuals provided information. The following are their comments.

- "A lot of people on my reserve are getting more and more addicted to heavier drugs."
- "Not all drug users are criminals."
- "There are too many young people using drugs in our community. Pot is not bad. Morphine and Oxy's are killing us, so do something about prescription drug abuse."
- "There are people accessing drugs at a very young age"
- "Why people feel the need to do the drugs they do. Have more free clean drug paraphernalia."
- "That most of us youth have a fuck it attitude and your wasting your time." Find or open something to help youth with addictions and problems with school, friends, etc."
- "That there are people experiencing drugs when they are not even a pre-teen yet."
- "However bad you think it is, it's 10 times worse. It's a bloody epidemic. The problems are being swept under the carpet and allowed to grow."
- "I need to know more about what the dangers are when I talk to you or any other worker."
- "I'm drug free 10 days now."
- "I'm really paranoid. I am on medication and don't use them properly."
- "It is 10 xs worse than you think on the streets. Try to get a new generation of educators/education/information."
- "Drugs are getting easier to have access to."
- "Only shot a couple of times."
- "Thunder Bay is a bad place for pills. The drugs are bad-cut wrong."
- "We are starting to get superior points works."
- "When are we going to get more help?"
- "That were using younger and younger."
- "Keep up the good work, it's a good cause."
- "I need to know if a HIV test is free and where to go."
- "Stupid questions - works etc."
- "I make more than you [individual indicated they were a methamphetamine cook]."
- "Love smoking crack."
- "This survey asked decent questions but it was quite ambiguous. But Good."
- "Don't Do Drugs."
- "I find some people use drugs responsibly and some do not. Teaching about drugs destroying personal relationships and making people selfish is an important aspect. I think drugs should be used by responsible individuals. I hope I am considered one."
- "Drugs are cool."
- "Education."
- "Find a way to eliminate hard drugs."
- "Legalize weed."
- "People use drugs whether you try to stop it or not."
- "Good Job."
- "Not all drug users come from the same background or fit a specific profile."
- "Mothers, take care of your daughters."
- "Too many drunks in Thunder Bay."
- "Grow a beard and shave your head."
- "I am a bisexual."
- "I love being high on crack also."
- "WEED IS NOT A GATEWAY DRUG."
- "Lots of drugs around."

- "I'd like for it to be easier to get a health card."
- "If hurtin' people got free drugs, there'd be a lot less crime."
- "Go bare back all the way."
- "Just to let you know this place is going down hill."
- "Get high everyday and drunk as a motherfucker."
- Nothing x 6
- What the coke is cut with."
- "Teach kids, students, high school students about this subject matter of factly."
- "Drug users don't always have the same look/education."
- "This city sucks."
- Jesus saves. Thanks for the sub."

Discussion and Recommendations

The purpose of this study was to identify the drug use prevalence among street-involved or at-risk youth, aged 24 years and under, living in the District of Thunder Bay, who use or at risk of using drugs. The Thunder Bay District Health Unit has identified, through statistical and anecdotal data that this population is not being served by services and programs that support drug use prevention or harm reduction strategies. The intention of this study was to develop recommendations for drug use prevention and harm reduction strategies, tools, and programs targeted at this population.

The peer outreach workers who collected the data were hired based upon their connections with the target population and were able to conduct 313 interviews. This exceeded our target of 300. This would not have been possible without the significant amount of time they volunteered above their contract of 15 hours per week. The outreach workers were excited and committed to this project.

Over 98% of the sample indicated drug use over the previous 12 months. Over 30% of the sample was injection drug users and over 38% of those who did not have a history of injecting knew someone who injects. This combined with the high prevalence of shared works both current (74.8%) and previous (61.3%) and with the majority (63.3%) of individuals who do not always use a condom when sexually active, compounds their risk of contracting and spreading disease and infection. This population is in high need of harm reduction programming and services.

The division of gender and ethnicity were similar. Over 28% of the sample reported being homeless and living either in a shelter or couch surfing, while 62% of the individuals indicated that they lived in an apartment or house. It was expected that none of the individuals would be residing on the street as data were collected during the winter months when temperatures in Thunder Bay sometimes reach below -40°C. Consequently most individuals had some form of shelter, although one individual indicated that they “lived on the street.” Despite the fact that the peer outreach workers were trained to assist the participants in completing the questionnaire, it is possible that the housing question on the questionnaire was unclear, given that the majority of individuals signified that they resided in a house or apartment. It is unclear whether these individuals resided with family or relatives, or contributed financially to their living situation. The peer outreach workers did identify a population of youth which do use drugs and who indicated a need for services and programming.

Confusion between cocaine and crack became apparent when the data was reviewed by the project’s consultants/ authors and the frontline staff of SPHRP. The data on cocaine and crack may be confusing. Crack use may be under-reported due to the social stigmatization of crack use compared to the more socially acceptable use of cocaine. The authors believe that the questionnaire and the peer outreach workers did not differentiate crack from cocaine use clearly. Study time constraints were a barrier to gathering accurate crack-cocaine data, as the peers were unable to establish trusting relationships with the participants. Further research must clearly differentiate crack from cocaine use.

The predominant drug categories used by youth were CNS stimulants, narcotics and cannabis. CNS stimulants were the most frequently cited category for drug of choice (36.8%, n = 112), the second most frequent category for drugs of convenience, and the most frequent category of drugs used over the previous six months.

Although cocaine was one of the most frequently cited drugs of choice and drugs used during the previous six months, methamphetamines and Ritalin were the most frequently reported CNS drugs of convenience and drugs used by the sample during that time period. The majority of individuals who indicated methamphetamines as their drug of convenience used CNS stimulants as their drug of choice. Seven individuals indicated methamphetamines as both their drug of choice and convenience.

CBC news reports that crystal methamphetamine (crystal meth) users:

“... can become addicted and dependent quickly, needing more and higher doses as the addiction progresses... Experts say that crystal meth is one of the most addictive street drugs and one of the hardest to treat. Addiction counselors say the relapse rate of 92 per cent is worse than cocaine... In Canada, however, provincial health insurance and government recovery programs can help the addict to recover.”

(<http://www.cbc.ca/news/background/drugs/crystalmeth.html>, February 22, 2005)

Anecdotal information from one of the peer outreach workers was that there were six active methamphetamine labs in Thunder Bay during the beginning of data collection in January 2005. At the end of data collection, three months later, two outreach workers reported 24 active methamphetamine labs. One of the participants indicated that he was a methamphetamine cook. Thunder Bay is just starting to see the ‘Meth Wave’ which has devastated other communities. Methamphetamine use, because of its low cost and easy accessibility, will likely increase.

Drug prevention and harm reduction strategies and programming need to reflect the issue of methamphetamine use before Thunder Bay experiences the negative effects felt by other communities. Thunder Bay’s programs and services should be proactive and aggressively plan for the ‘Meth Wave’ by developing and targeting prevention and harm reduction strategies. Thunder Bay should learn from other communities where methamphetamine use has become predominant. Although community and public educational sessions regarding the effects of methamphetamines have already begun, they need to continue.

Narcotics were identified by 18.8% (n = 57) of individuals as their drug of choice, and 18.1% (n = 54) as a drug of convenience, and as the third most frequently used drug category by individuals during the previous six months. The majority of these drugs were pharmaceutical pills.

Pharmaceutical pills, in particular narcotics and CNS stimulants, should also be targeted for prevention and harm reduction strategies as they were 15.6% of drugs of choice, 25.2% of convenience drugs, and 31.4% of drugs the sample used during the previous six months. Pharmaceutical pills are readily accessible to youth.

Over 69% reported that their drugs of choice and convenience differed mainly due to cost (45.7%; n = 148) and difficulties accessing their drug of choice (26.2%; n = 87). Other less-often cited reasons included problems of location of using drug of choice (n = 8) and either not having or difficulties accessing the required works (n = 2).

The predominant route of administration is smoking followed by snorting for both drugs of choice and convenience. Insertion and transdermal patches were both used rarely for drugs of choice and convenience. Injection was more prevalent for drugs of choice (9.9%, n = 64) than convenience drugs (12.4%; n = 52). Forty-seven individuals indicated they inject as a route of administration for both their drugs of choice and convenience. CNS stimulants were the most frequently injected drug category followed by narcotics for both drugs of choice and drugs of convenience.

Harm reduction services and programs, such as Superior Points Harm Reduction Program need to continue to provide harm reduction services to IDUs. Services need to reflect the needs of the injection population and what they are injecting. The data indicated that seven of the injectors were less than 16 years of age. Research indicates that modeling of injection drug use influences injection drug use among peers. Individuals are taught to inject by other injection drug users. Over 38% (n = 120) of the sample who has never injected knows someone who injects. The potential exists for youth in Thunder Bay to become problematic drug users. Harm reduction programming needs to connect with Thunder Bay's youth.

Although the number of individuals who share works is decreasing, the majority of individuals (61.3%) currently share works. Eighty percent of individuals who previously shared works continue to do so. Forty-six percent of individuals who currently share works and 43.5% of individuals who never shared works had never accessed or used sterile supplies. Interestingly, Thunder Bay's harm reduction programming is reaching over 60% of the injection drug users, which is more than the Montreal study in which 24% of IDUs report not sharing works. (Public Health Agency of Canada; Hepatitis C Resource Library; "IDU in Canada" Available at: http://www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/careDiscCanada/idu.html)

The most frequent shared works were snorting equipment (bills and straws) followed by smoking equipment (pipes). Over 68% of the sample (n = 214) identified that they share pipes when asked specifically about this category of works. Injecting equipment was shared less frequently (16.6%) however this is reflected by a small population of injectors. The Thunder Bay District Health Unit's Superior Points Harm Reduction Program also provides education on clean injecting and distributes free sterile injection supplies. Shared injection equipment consisted of needles (n = 63), ties (n = 17), spoons (n = 11) and water (n = 4).

The reasons identified by participants for current sharing of works were: inconvenience of using clean works (n = 73); fear of asking for clean works (n = 61); cost of clean works (n = 59); problems accessing clean works (n = 58); and difficulty using clean works (n = 26). It appears that the sample knows about the dangers of sharing works but chooses to share because the works are either not readily available when the drugs are

being used or individuals are afraid to request clean works. It may be the case that individuals do not know the dangers of sharing some works such as ‘snorters’ and pipes as this equipment have not been targeted by high publicity education campaigns.

The spread of disease and infection, such as HIV and hepatitis, through the sharing of drug paraphernalia or equipment which may contain blood or transmissible viruses is well documented in the literature. Public education initiatives have attempted to address this, yet the majority of respondents continue to share their works with the predominant reasons being cost, availability and access. Education needs to continue.

Further harm reduction strategies should include the continuation of distribution of sterile works, including injection supplies; however the spectrum of distributed works should be expanded to include pipes, sterile snorting equipment, and drug test kits. Pipes and snorting equipment are works that if shared may contain blood or other transmittable viruses and consequently can spread disease and infection. Drug test kits would allow individuals to know what they are taking.

Clean works need to be available and easily accessible, as well as youth must want to access them but may have hesitancies doing so. Harm reduction education on the safe use of works, as well as the spread of infection and disease through the sharing of works needs to continue. Education should also include the transmission of disease and infection through these works, as well as the right of individuals to request clean works.

In addition harm reduction education should target this population directly. The barriers need to be identified and overcome. Education on what works are available and how to access them would be beneficial. An education campaign should be provided on the accessibility of clean works and should stress confidentiality, non-judgmental support, and lack of reprisals or sanctions.

Consideration of ‘Safe Injection Sites’ and prescription heroin should be considered within the spectrum of harm reduction strategies. Ongoing research on these strategies is proving efficacious. Another focus in the reduction of harm at the judicial level is further decriminalization of drug use because this may promote sustained behavior change.

Haden (2002) challenges the dichotomy of the legalization and the criminalization of intravenous drugs from a public health perspective, exploring eight legal options for illicit drugs and their interaction with user marginalization, the black market, and levels of drug consumption. The eight legal options include: 1) free market legalization; 2) legalization with product restrictions; 3) market regulation; 4) allow drugs to be available by prescription; 5) decriminalization; 6) *de facto* legalization or *de facto* decriminalization; 7) depenalization; 8) Criminalization. Haden indicates:

As the debate on harm reduction and drug policy reform intensifies, our understanding of these eight policy options and their health, social and criminal consequences needs to be expanded and developed. The process of examination of these eight legal options for all currently illegal drugs will produce significant benefits for society, drug users and drug abusers. The

desired end result is an evolution of our illegal drug laws and policies. Canadian society will not manage its “drug problem” effectively until we reach a place where addiction is viewed first and foremost through the lens of public health, and addicts and drug users are treated with dignity and respect.

The use of condoms when sexually active has multiple harm reduction benefits which includes prevention of sexually transmitted diseases and the prevention of unwanted pregnancies. Although the majority of respondents (77.6%) indicated that they do access free condoms, sixty four percent do not always use condoms when sexually active. Thirty four individuals (10.9%) indicated that they never use a condom. Reasons for not using a condom are unavailability, not liking the feeling when using one, and using alternate forms of birth control. Other reasons were forgetting to use one and not knowing one was not used.

Education on the harm reduction benefits of condom use needs to continue. Although free condoms are made available to the public, they may not be readily accessible to the target population. Additionally, individuals may not plan ahead. Condoms need to be readily available and accessible for them to be used when individuals do not plan ahead. They should not only be made available through health care establishments but located where youth can easily access them such as where they typically gather.

Although the majority of respondents (70%) do access the health care system 18.5% do not. There is a definite and well publicized shortage of health care practitioners in Northwestern Ontario. Many residents of Thunder Bay do not have a family physician and must access health care through walk-in clinics or the emergency room. Walk-in clinics may not always be easily accessible because of their hours of operation and locations. The Thunder Bay Nurses Registry does provide information on walk-in clinics. The Thunder Bay Nurses Registry is not commonly known as a resource in the community, particularly among youth. The availability of walk-in clinics in Thunder Bay, does not replace the need for family physicians that can provide on-going follow-up, particularly for individuals with compromised health. This issue is exacerbated when the individual is perceived by the health care systems as drug seeking and/or non-compliant. This is compounded by mental health issues, active drug use, and homelessness.

The most frequent cited difficulty was not having an Ontario Health Card, having an expired card or not having the proper identification to get one. A health card is necessary for accessing any health care in Ontario. Although there is a location in Thunder Bay to apply for and update health cards, individuals may experience difficulty with approved identification and proof of residency requirements. They may only learn of these once attending this office. Education on the location of the health card office, the telephone number as well as the need for required identification and proof of residency for updating and applying for a health card would be beneficial for the health care service providers themselves. Assistance with obtaining or updating a health card or education on how this can be accomplished would benefit individuals.

The most apparent need that is required for programming and services to the target population is the development and maintenance of connectivity to this population. The use of peer outreach workers who had connections with the target population increased our ability to collect data. The sample also identified the need for a youth specific harm reduction worker. To target services to an unfamiliar population requires connections with it. The employment of youth specific harm reduction workers with already established connections would be more cost effective than building new connections. Furthermore, trusting and therapeutic relationships can be built and maintained with time, however connections will constantly have to be built as service recipients will continue to change with the continuing influx of youth entering the target population.

It was apparent that the peer outreach workers had the required connections with the intended target population of the study. Peer outreach workers will be instrumental in the development of programs and linkages in any future endeavors.

Community programs and agencies will need to be educated on the populations' needs and community and inter-agency partnerships will have to be built.

Research regarding the drug use habits and trends of street-involved and at-risk youth, less than 25 years of age in Thunder Bay, who are use or at risk of using drugs, should be on-going to continue to develop and implement drug prevention and harm reduction programming and strategies for this population. Future research should be conducted during the summer or warmer months as it is expected that there would be a more transient population. Furthermore the warmer weather would allow for individuals to live on the streets. The drug use trends and needs of this population may change.

The development and delivery of drug use prevention and harm reduction programming requires continual funding to have sustainability. It will take some time for programs and services to build connections with this population which is currently neglected. This will be a continuous and never ending process with the influx of new youth and issues. Consequently continual funding and commitments will be required by all levels of government.

“Today at the bus terminal there was used rigs along the garbage infested ground. Urg I don't want this job to end. NOPE.” Peer Outreach Worker

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Appendix A

Thunder Bay Youth Drug Use Questionnaire

Have you filled out a questionnaire previously? Yes No

Purpose

This Drug Use Questionnaire is from *Superior Points*, as they try to improve harm reduction and other services to you. This study is supported by The Thunder Bay District Health Unit and Health Canada. We will use your information to improve our services or to develop new ones.

The interview will take about 10 minutes.

Participation is voluntary and all information will be confidential. We won't collect names, so make sure you don't sign yours – we want this set up so that even we couldn't identify you, even if we wanted to.

If you want to just skip one or more questions but answer the others, that's OK. If at any time you wish to end the interview, just say that and we'll stop. You're in control.

Consent

We do need to be able to prove that everyone who responded to our questionnaire really agreed to do so. Your initial below will do – don't sign your full name.

1. I understand the purpose of this study, and how my information will be used.
2. My participation in the interview is voluntary.
3. I can withdraw at any time.
4. My answers are anonymous and no identifying information will be collected.

Initial: _____ Date: _____

Section 4: Sharing Works (Works can include needles, passing joints, bills, etc.)

Have you ever injected drugs? Yes No
 Do you access and use clean works/supplies? Yes No
 Have you ever shared works previously? Yes No

If you have shared works in the past, what was the reason? (check all that apply)

Cost of works Inconvenient to use clean works
Problems with accessing works Difficulty with using works safely/property
Others share with me afraid to ask for clean/new supplies
Other (please list) _____

Do you share works currently? Yes No

If yes why? (check all that apply)

Cost of works Inconvenient to use clean works
Problems with accessing works Difficulty with using works
Others share with me afraid to ask for clean/new supplies
Other (please list) _____

What part of your works have you/do you share?

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If you smoke crack (or other drugs), do you share your pipe? Yes No

Section 5: Other Harm Reduction Questions

When sexually active do you use a condom?

Always Frequently Sometimes Rarely Never

If you don't use condoms, why not? _____

Do you have access to free condoms? Yes No

Do you access health care? (e.g. Walk-in clinics, doctor, nurse, etc) Yes No

Do you have any problems with accessing health care? Yes No

(Please list) _____

What services would you like to see developed in the community?

Is there a need for a youth specific harm reduction worker in T. Bay? Yes No

Would you use a drug test kit if you had free access to one? Yes No

What else is it important for us to know?

Questionnaire #	«num»
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Appendix B

Peer Journal Comments

“The problem with today’s youth with drugs is a number of reasons for one nowadays its fucken cool to smoke pot or eat shrooms, go out drinking do pills. I hear it in music all the time which I don’t mind but when I listen to a song that says smoke crack or shot up, that doesn’t mean I’m going to do it, but some do.”

“I know youth and friends that will got to a place where there are cops sitting in there and they’ll still going to buy drugs, why? Because first of all there easy to get in any amount and second of all there fucken hooked on these fucken stupid pills. I sit and watch them go in and laugh because why the fuck would you want to get busted over a 25 dollar pill. Because they are hooked.”

“...then they go to a doctor and say oh this drug is ruining my life and instead of him getting off the drugs he’s fucking hooked on, the doctor gives him more drugs to get off those drugs.” “I’m not a doctor but I’m sure there is another ways b4esides giving them more fucking drugs.”

“A very well informed individual, wanted to help out a lot, wasn’t aware of the dangers of sharing bills. I felt that informing him I was doing something positive. He was so intelligent it left me feeling a bit confused as to how he fell into it.”

“I went to a north side bar and completed 2 surveys. As well as arranged a time to do another. Both people I surveyed were reluctant at first but once they read the purpose they were more then happy to give me their time. Some asshole vomited on my bag. The surveys survived but that little brown stain on the corner of the pages is vomit, FUCKING GROSS”

“ an individual that was clearly high or on something – exhibited many signs of it as well...inability to make eye contact, glossy red eyes, broken speech - . Said he never didn’t do drugs. It sure seemed like he ways lying but I guess there wasn’t a whole lot I could do.”

“I ran into an old friend at a north side bar. I was actually really surprised and kind of shocked to find out what kind of stuff he had been doing, but I guess that’s part of the job.”

“A girl came into work today asking if someone here had the drug surveys. She was so nice. So helpful. She shared a story with me that gave me a sick feeling in the pit of my stomach. She had gone to one of the places for PAP test and for 3 years she was asking about little spots she had. They were dismissed as ingrown hairs. It was only recently that it was properly diagnosed as HPV.....maybe HBV. Scary fucking shit.”

“Yesterday and today have been shitty for finding people. It seems like no one wants to talk to me. I did manage to get the surveys I have done. Got turned down like 20 times though.”

“Predominately among the people I know, used to know, and have surveyed cocaine has been the favorite drug of most people though the use of ecstasy is quite popular.”

“It seems that people who use stuff via new means need assistance their first few times.”

“A lot of people are undereducated when it comes to diseases and the transfer of them.”

“I believe there should be a lot more education on the lower side of drug use i.e. Safe use. It seems that not enough young people know about superior points and what services they offer.”

“There seems to be lots of coke use, not a lot of education, way less condom use then I thought!!!!!!!!!!!!, ecstasy seems like it is becoming much more popular among people that I thought wouldn't have done it.”

“The people I have talked to so far have been good. I mean , it was a lot easier than Id thought. The first one I got done, I said, it doesn't have to be your real initials, just sign a letter from the alphabet and dude wrote down the entire alphabet.”

“One of my young friends is got HEP C and moved to T.O. for treatment but sadly is back on the streets. She got it by not using a clean rig. I guess this job is kinda an accomplishment. Giving help to those I actually know need it. I'm just doing questionnaires abut being part of the good side feels AWESOME.”

“Its been a crappy last couple days but tonight I re-load on surveys. Didn't sleep well last night, I deep thinking back...I hope those “thoughts” go away soon. OH one dude I did a questionnaire on I've know since we were little but he is young and now I seem to be running into him alto. But it seems he cant even look at me ah shitI think next time I see him Ill tell him I was there and see if he needs someone to talk to.”

“Man now I don't want to sleep. I wanna GO! Do surveys, find people, help.”

“I've also noticed most of the junksters I know of/ talked to don't want their sub coupon or don't notice it. EAT EEAATT!!!!”

“Well I went back to dudes house but only two people were there. Lucky it was the two people I was looking for. Guy was like “I want Heroin”, and me and dude were trying to tell him it woulda been a bad idea.....he wanted to do a half gram slam.....um fuck.”

“I saw and old friend from Thunder Bay, she's good, off drugs, on methadone. I was scared for her, she's younger then me.”

“I did one her. It was hard though, she was all sketched and pacing the area. I asked her do you know someone who shoots up, she’s like yeah you shoot up people who have trouble.”

“ A group of buddies were having a sauna party. I got some surveys done there and the topic for a while was Sharing. Dude was there and has been using longer than the rest (hardcore) but because he’s been hanging out with the rest recently I guess nobody thought to ask, heylike are you all good?! He looked pretty rough compared to how he used to.”

“Blow and oxy’s are becoming too freakishly common.”

“Did ya know people who use morphine or oxy’s would have a longer natural lifespan (if ya don’t OD) because it slows down your system or puts it relaxed.”

“QUESTION? If some one has been using for a really long time and enjoys it very much, but are suddenly put in a situation where they cant use for a goodyear, what are the chances they’ll go back to it?”

“ I remember when I was still shooting and we went to (place location here) and a Superior Points van showed up there I think to check things out or something. But I was like I wanna do something like that someday....I do, yup, yup.”

“It really sucks cause time is just about up. Things I’ve learned 1. kids like drugs. Drugs are fun. 2. disease is too common 3. PEOPLE ROCK. Hey this was like my dream job, so at least I can say I worked my dream job.”

“Today at the bus terminal there was used rigs along the garbage infested ground. Urg I don’t want this job to end. NOPE.”

“Thunder Bay is infested with drugees who need help and it was great being able to do my part.”

“Met with a group of young people at a Northside Apt to conduct surveys. One was the renter and the three others couch surfing there. Friends you there to use. Biggest issue of use is accessing clean works. None had ever been tested for HIV or HEP C. Housing big issue and lack of work.”

“Interesting use of coke for a couple of youth, to get more drunk. I have heard this quite often on my life. Party folk using coke recreationally to keep parting.”

“Just some random thoughts. When does recreation become use and can on pinpoint it. How do we begin to secure housing for youth whim it is a concern?”

“I have seen that alcohol has become a given. It is no longer a party just to get a 12 pack or 24 pack. Drugs are the culture. It seems that the trends are determined by availability. One seems pre-disposed to use, whatever that substance may be. You can control crime

by giving on what ever they may choose and treating the issue of use as a health problem.”

“I think they should have testers for E to ensure its good to go. Clean gear is also a good idea such as needles, pipes, snorters. There is too much risk of disease today and this would lessen the risk. People will experiment no matter if they have clean shit or not so it may as well be supplied for them.”

“Crystal Meth has hit Thunder Bay. I am not sure if this scares people as much as it scares me. I have seen meth some many times eat the minds of friends of mine. I am not sure that people understand that this is a drug that does nothing but fuck your whole life up. It may be the only drug that I have seen and used that completely changes you for the worse. There has never been a drug or lifestyle that makes me more nervous.”

“Thunder Bay is COKE TOWN, Thunder Bay is METH TOWN. The faster you get the better it is.”

“As I am doing surveys I am seeing meth use go up. This is directly reflecting the info from the street of 12 meth labs being set up since January and its only mid February. Hold the fuck on Thunder Bay its about to get very weird. We had better get more peers on the street to work with the youth armed with information, test kits, CPR, cause it is going to get ugly out there.”

“Its an interesting thing being in a drug culture. You take for granted bad things will happen; friends will get really fucked up, you will get really fucked up. Not every action will have positive outcome. You even understand that some folks around you are on borrowed time. However to see the destruction that meth has when it hits the street is bizarre to me. Just look at Vancouver’s eastside and the effect meth has had on it, unthinkable for a community that was so well defined and living (believe it or not squares) in a sort of harmony. BLAH BLAH BLAH Lets just play golf.”

“Hunter S Thompson died last night. From the reports I have heard he put a bullet into his head. I guess its better to burn out than fade away. Not sure if Hunter burned out but I can be sure from what I know that the physical being con only take so much. If we expect our bodies to keep up with our minds we will surely fade away over time. It’s a choice, a lifestyle, just that. Not better or worse then any other, just a choice.”

“Well from all indications Thunder Bay is in for some very trying times. Our economy is crumbling and as everyone knows shit rolls down hill. Resulting in the problems of the city resting on the youths shoulder. What are we to do; in true Thunder Bay style everyone is escaping into different means, mostly turning to drugs and very strong drugs. I am at a lose considering how little there is to combat the issue in our city, I can only pray that we survive, Fuck this job really sucks sometimes, I hate seeing friends die.”

Appendix C

Contact Information for the Thunder Bay District Health Unit

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