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The Cedar Project: Negative health outcomes associated with involvement in the child welfare system among young Indigenous people who use injection and non-injection drugs in two Canadian cities

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ABSTRACT

OBJECTIVES: Indigenous leaders and child and family advocates are deeply concerned about the health impacts of the child welfare system, including HIV vulnerability. The objectives of this study were to describe the prevalence of having been apprehended into the child welfare system and associated HIV vulnerabilities among young Indigenous people who use drugs.

METHODS: The Cedar Project is a cohort of young Indigenous people ages 14–30 years who use illicit drugs in Vancouver and Prince George, British Columbia. Multivariable logistic regression modeling determined associations between a history of involvement in the child welfare system and vulnerability to HIV infection.

RESULTS: Of 605 participants, 65% had been taken from their biological parents. Median age of first apprehension was 4 years old. Having been sexually abused, having a parent who attended residential school and being HIV-positive were all independently associated with having been involved in the child welfare system. Participants who had been involved in the child welfare system were also more likely to have been homeless, paid for sex, diagnosed and hospitalized with mental illness, self-harmed, thought about suicide, and attempted suicide. Among participants who used injection drugs, those who had been involved in child welfare were more likely to have shared needles and overdosed.

CONCLUSION: This study has found compelling evidence that young Indigenous people who use drugs in two cities in BC are experiencing several distressing health outcomes associated with child welfare involvement, including HIV infection. Jurisdictional reforms and trauma-informed programs that use culture as intervention are urgently needed.

KEY WORDS: Child welfare; HIV; substance-related disorders; Indians; North American

La traduction du résumé se trouve à la fin de l'article.

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Prior to the arrival of European missionaries and settlers, Indigenous families and communities supported healthy, independent children through spiritual connection to lands, traditions, language and culture.[1] However, traditional styles of parenting were critically disrupted between 1874 and 1996, when the Canadian government and religious institutions forcibly removed over 150,000 Indigenous children into residential schools in an effort to control what was termed the "Indian problem".[2] Children in residential schools were taught to be ashamed of Indigenous identity, and physical, sexual and emotional abuses were common.[2,3] These experiences in turn significantly impacted survivors' parenting styles and capacities and the consequent intergenerational trauma affects young Indigenous people today.[4–7]

In 1951, an amendment of Section 88 of the *Indian Act* transferred jurisdiction of Indigenous child welfare from the federal government to the provinces. Under this new scheme, funds were transferred to the provinces based on the number of children apprehended from families. As a result, between 1959 and the late 1960s, it is estimated that the proportion of Indigenous children in the child welfare system increased from 1% to 40% in Canada in what is known as the "Sixties Scoop".[8]

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Conflict of Interest: None to declare.

Although agreements in the 1980s between First Nations and provincial governments established delegated Aboriginal Agencies for child welfare services, jurisdictional authority over child welfare remains with provincial governments for Indigenous children on- and off-reserve. Splatsin in Secwepemc territory, British Columbia (BC), is the only First Nation in Canada that has exclusive jurisdictional authority over custody proceedings involving children who belong to the Splatsin Indian Band and reside either on- or off-reserve. This unprecedented achievement was a result of the community developing a bylaw in 1981 based on traditional law and child protection practices of the Splatsin people (rather than provincial laws) and political recognition at the provincial and federal levels.[9]

In the early 1990s, Indian and Northern Affairs Canada (INAC) initiated Directive 20-1 to restructure operations and funding for delegated First Nations CFS (Child and Family Services) Agencies. The funding formula of Directive 20-1 has been severely criticized by internal INAC reports, the Assembly of First Nations, and the Auditor General of Canada as it requires that the child be removed from the home prior to the release of funds to support the child.[10] Further, Directive 20-1 does not provide resources for in-home family support for at-risk children, supplemental services, preventive or educational programs.[10] Recommendations for changes to Indigenous child welfare policies by the First Nations Child and Family Caring Society of Canada and BC's Representative for Children and Youth – such as coordination with public health, enacting Jordan's Principle,*[11] providing adequate support for delegated Aboriginal Agencies and focus on housing for vulnerable families – have yet to be implemented.[10,12] Consequently, in 2011, Indigenous children in BC were 7.4 times more likely than non-Indigenous children to be taken into the child welfare system.[9] In 2013, Indigenous children comprised more than 52% of children in the system.[9] Further, in 2010 the BC Ministry of Children and Family Development reported that in the northern region of the province an astonishing 79.6% of children in foster care were Indigenous children.[13] Current estimates indicate there are three times as many Indigenous children in the child welfare system in Canada as there were children enrolled in the residential school system at its peak in the 1940s.[14]

Indigenous leaders and child and family advocates are deeply concerned about the health impacts of the child welfare system, including HIV and HCV vulnerability.[15] In the past decade, young Indigenous people who use drugs have emerged as one of the populations at highest risk for HIV infection in Canada.[16] The objectives of this study were to describe the prevalence of having been apprehended into the child welfare system among young Indigenous people who use drugs, and to describe vulnerability to HIV infection and negative health outcomes associated with child apprehension. As advocated by Indigenous scholars, we aimed to situate these findings within the context of historical trauma.

*Jordan's Principle ensures that Indigenous children do not experience denials, delays or disruptions of services as a result of jurisdictional disputes. The principle emerged after Jordan River Anderson (Norway House Cree Nation) encountered tragic delays in services while in care prior to his death in 2005.

METHODS

The Cedar Project is a prospective cohort study involving young Indigenous people who use drugs in Vancouver and Prince George, BC. Previous studies have described the methodology of the Cedar Project in detail.[17] Briefly, participants were recruited through referral by health care providers, community outreach, and word of mouth. Young people were eligible for the study if they were aged 14 to 30 years and had smoked or injected illicit drugs, aside from marijuana, in the month prior to enrolment. Participants self-identified as descendants of the First Nation Peoples of North America, including Métis, Aboriginal, First Nations, Inuit and status and non-status Indians. Drug use was confirmed using saliva screens (Oral-screen, Avitar Onsite Diagnostics). The development and conduct of this study followed the guidelines provided in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Human Subjects, with particular attention to Chapter 9 pertaining to research involving Indigenous peoples. Indigenous collaborators from the Cedar Project Partnership were involved in the conception, design and implementation of the Cedar Project, reviewed these results, and approved this manuscript for publication. The University of British Columbia - Providence Health Care Research Ethics Board also approved the study.

An Indigenous study coordinator met with all eligible participants to explain procedures, collect informed consent and confirm study eligibility. At enrolment, participants completed a detailed interviewer-administered questionnaire designed to collect data on socio-demographic characteristics, drug use patterns, injection practices and sexual vulnerabilities. Venous blood samples were drawn and tested for HIV and hepatitis C; trained nurses provided pre- and post-test counseling. Participants were requested, but not required, to return for their HIV/HCV test results, at which time referrals for care would be provided. Study personnel worked actively with the participants to secure whatever physical and emotional support they requested, including access to traditional healing, drug treatment and housing. Participants received a $20 stipend at each study visit as compensation for their time and to facilitate transportation.

This analysis is based on the baseline questionnaire of 605 participants recruited from October 2003 to November 2007. The primary exposure variable of interest was ever having been in the child welfare system. Study interviewers asked participants: "Were you ever taken from your biological parents?" Response options were yes or no. We have therefore used a history of child welfare involvement to describe this variable.

All outcomes were determined based on their a priori importance to HIV vulnerability. Socio-demographic variables of interest included age and gender. Traumatic life events variables included homelessness, involvement in sex work, ever having been incarcerated, having a parent who attended residential school, and ever having been sexually abused. Homelessness was defined by asking "have you ever been 'on the street' with no place to sleep for more than three nights?" Involvement in sex work was defined as reporting exchanging sex for money, food, alcohol and/or drugs in the past six months. Mental health

indicators included suicide ideation, self-harm, suicide attempt, diagnosis of mental illness, and hospitalization due to mental illness. Drug use variables included type of drug, frequency of drugs used, and syringe sharing. Frequent drug use was defined as using drugs daily or more often. Binge drug use was defined as periods when drugs were used at a higher frequency. Sexual vulnerabilities included having had more than 20 sexual partners, having a sexually transmitted infection (STI) in the past six months, and inconsistent condom use with casual (relationship for <3 months) and regular (relationship for >3 months) sexual partners.

ANALYSIS

Descriptive analysis was performed for the entire sample and for a subset of those who reported injecting drugs. Bivariate categorical data were used to conduct Pearson's χ^2 test and Fisher's exact methods when expected cell values were less than five. Continuous data were analyzed using the Wilcoxon rank-sum test and Student's *t*-test where appropriate. Unadjusted and adjusted odds ratios and 95% confidence intervals were obtained using bivariate and multivariate logistic regression to determine associations between child welfare involvement and outcome variables. Statistical significance was at the 0.05 level in unadjusted analyses. Covariates adjusted for in multivariate models included age and gender. Childhood sexual abuse was tested but not included as a confounder in final models, as inclusion of the variable did not significantly change the coefficients (data not shown). All reported *p*-values are two-sided. Statistical software SPSS (Mac 16.0 version) was used to run the analyses.

RESULTS

Overall, 65% of participants reported removal from their biological parents into the child welfare system during childhood. Median age of first apprehension was 4 years old (range: 0–19 years). Among those who reported child welfare involvement, 71% were taken into foster care, 42% were taken into group homes, 37% were taken to relatives and 12.5% were adopted. These were not mutually exclusive categories as many participants had repeated experiences of being taken from parents. Most (84%) participants reporting child welfare involvement stated that they had been taken involuntarily.

Tables 1 and 2 compare demographic characteristics, traumatic life events, drug and sex vulnerabilities, and health outcomes between participants who reported child welfare involvement and those who did not. Tables 3 and 4 present the unadjusted and adjusted logistic regression models. The reference category in all cases was participants who reported no involvement in child welfare. In unadjusted analyses, child welfare involvement was significantly associated with: having a parent who attended residential school (Unadjusted Odds Ratio [UOR]: 1.8, 95% Confidence Interval (CI): 1.2–2.8); ever having been sexually abused (UOR: 2.1, 95% CI: 1.5–3.0); ever being homeless (UOR: 1.5, 95% CI: 1.0–2.1); ever having been involved in sex work (UOR: 1.7, 95% CI: 1.2–2.5); starting sex work at a younger age (UOR: 2.0, 95% CI: 1.1–3.6); being HIV-positive (UOR: 2.1, 95% CI: 1.0–4.3). In addition, child welfare involvement was significantly associated with: ever having self-harmed (UOR: 1.6, 95% CI: 1.1–2.2); ever having attempted suicide (UOR: 1.4, 95% CI: 1.3–2.5); ever having been diagnosed with (UOR: 1.6, 95% CI: 1.1–2.3) or hospitalized for (UOR: 1.8, 95% CI: 1.1–2.8) mental illness. Among participants who used injection drugs, child welfare involvement was associated with: ever having shared used rigs (UOR: 1.8, 95% CI: 1.1–2.8); recent rig sharing (UOR: 2.3, 95% CI: 1.2–4.6); ever having overdosed (UOR: 2.6, 95% CI: 1.6–4.2).

In multivariable models controlling for age (UOR: 1.7, CI: 1.2–2.3) and gender (UOR: 1.4, CI: 0.96–1.9), child welfare involvement was independently associated with: having been sexually abused (AOR: 2.6, CI: 1.7–3.8); being HIV-positive (AOR: 2.4, CI: 1.2–5.1); having a parent who attended residential school (AOR: 2.1, CI: 1.4–3.2); ever having had suicide ideation (AOR: 1.8, CI: 1.3–2.6); ever having been diagnosed with (AOR: 1.6, CI: 1.1–2.3) or hospitalized for (AOR: 1.7, CI: 1.1–2.7) mental illness; ever being homeless (AOR: 1.7, CI: 1.2–2.4); ever being involved in sex work

Table 1. Comparison of baseline characteristics between Cedar Project participants who were taken into the child welfare system and those who were not

	Taken (*n* = 391) *n* (%)	Not taken (*n* = 214) *n* (%)	*p* value
Demographic characteristics			
Median age (years) at baseline (range)	22.8 (14–31)	24.4 (15–31)	0.001
Female gender	199 (50.9)	93 (43.5)	0.080
Lived in Vancouver	195 (49.9)	105 (49.1)	0.850
Traumatic life experiences			
At least one parent attended residential school	185 (69.8)	93 (55.7)	0.003
Experienced sexual abuse	212 (54.8)	76 (36.2)	0.000
Age of first sexual abuse under the cohort median (6 years)†	86 (42.0)	26 (35.6)	0.343
Ever on the street for >3 nights	274 (70.3)	131 (61.8)	0.035
Ever in prison overnight	306 (78.3)	174 (81.3)	0.376
Age of first prison stay under cohort median (16 years)†	122 (51.5)	63 (47.7)	0.490
Sexual vulnerabilities			
More than 20 lifetime sexual partners	197 (51.3)	100 (47.8)	0.421
Inconsistent condom use with regular partner	35 (18.1)	17 (17.5)	0.899
Inconsistent condom use with casual partner	76 (52.4)	47 (60.3)	0.261
Had sexual partner who uses injection drugs in the past six months	53 (27.2)	26 (26.5)	0.906
Ever involved in sex work	163 (49.5)	68 (36.2)	0.003
Age of first involvement in sex work under cohort median (16 years)†	77 (47.5)	21 (31.3)	0.024
Drug-related vulnerabilities			
Daily or more crack smoking	215 (62.0)	115 (60.2)	0.690
Binge drug smoking	193 (49.9)	115 (54.5)	0.279
Ever injected drugs	215 (55.0)	120 (56.1)	0.767
Health outcomes			
Ever self-harmed	163 (41.9)	67 (31.5)	0.012
Ever seriously considered suicide	226 (57.8)	93 (43.5)	0.001
Ever attempted suicide	156 (40.0)	68 (31.8)	0.046
Ever diagnosed with mental illness	130 (33.4)	52 (24.4)	0.022
Ever hospitalized for mental illness	82 (21.2)	28 (13.3)	0.018
Ever had a sexually transmitted infection (STI)	158 (40.4)	89 (41.6)	0.778
Had an STI in the past six months	39 (10.0)	16 (7.5)	0.307
Hepatitis C positive antibody status	122 (33.0)	67 (33.8)	0.835
HIV positive antibody status	37 (9.6)	10 (4.9)	0.042

Note: Although the total number of participants included in this study is 605, participants who were unsure of the answer or refused to answer a particular question were excluded from the proportions presented here. Percentages were calculated based on the total number of participants who responded yes or no to the question, resulting in slightly different sample sizes for each variable.
† Dichotomized at the cohort median.

Table 2. Comparison of baseline injection-related vulnerabilities between participants who were taken into the child welfare system and those who were not, among Cedar Project participants who reported injection drug use

	Taken (*n* = 215) *n* (%)	Not taken (*n* = 120) *n* (%)	*p* value
Age of first injection under cohort median (17 years)†	77 (36.0)	50 (41.7)	0.304
Ever overdosed	99 (46.0)	30 (25.0)	0.000
Daily or more heroin injection	55 (60.4)	37 (62.7)	0.780
Daily or more methamphetamine injection	14 (36.8)	6 (35.3)	0.912
Daily or more cocaine injection	61 (51.7)	25 (42.4)	0.242
Daily or more speedball injection	22 (48.9)	8 (28.6)	0.086
Binge injection drugs use in the past six months	116 (54.0)	65 (54.2)	0.970
Ever needed help injecting	124 (57.7)	66 (55.0)	0.636
Needed help injecting in the past six months	68 (39.8)	34 (35.8)	0.523
Ever fixed with a used needle	80 (37.2)	30 (25.0)	0.023
Fixed with a used needle in the past six months	44 (20.5)	12 (10.0)	0.014

Note: Although the total number of participants included in this study is 335, participants who were unsure of the answer or refused to answer a particular question were excluded from the proportions presented here. Percentages were calculated based on the total number of participants who responded yes or no to the question, resulting in slightly different sample sizes for each variable.

† Dichotomized at the cohort median.

Table 3. Unadjusted and adjusted logistic regression analyses of health outcomes and HIV vulnerabilities associated with having been taken into the child welfare system among Cedar Project participants† (*n* = 605)

Outcome	UOR (95% CI)	AOR (95% CI)
At least one parent in residential school	1.8 (1.2–2.8)*	2.1 (1.4–3.2)**
Ever sexually abused	2.1 (1.5–3.0)**	2.6 (1.7–3.8)**
Ever on streets for >3 nights	1.5 (1.0–2.1)*	1.7 (1.2–2.4)*
Ever been paid for sex	1.7 (1.2–2.5)*	1.7 (1.1–2.8)*
Age first involved in sex work under cohort median (16 years)‡	2.0 (1.1–3.6)*	1.8 (0.9–3.3)
Ever self-harmed	1.6 (1.1–2.2)*	1.5 (1.1–2.2)*
Ever seriously thought about suicide	1.8 (1.3–2.5)**	1.8 (1.3–2.6)*
Ever attempted suicide	1.4 (1.0–2.0)*	1.4 (1.0–2.1)*
Ever diagnosed with mental illness	1.6 (1.1–2.3)*	1.6 (1.1–2.3)*
Ever hospitalized for mental illness	1.8 (1.1–2.8)*	1.7 (1.1–2.7)*
HIV antibody status	2.1 (1.0–4.3)*	2.4 (1.2–5.1)*

UOR = unadjusted odds ratio; AOR = adjusted odds ratio; 95% CI = 95% confidence interval.

† Reference group includes all participants who were not removed from biological parents.

‡ Dichotomized at the cohort median.

* $p < 0.05$; ** $p < 0.001$.

Table 4. Unadjusted and adjusted logistic regression analyses of health outcomes and HIV vulnerabilities associated with having been taken into the child welfare system among Cedar Project participants who reported injection drug use† (*n* = 335)

Outcome	UOR (95%)	AOR (95%)
Ever fixed with a used needle	1.8 (1.1–2.9)*	2.0 (1.2–3.4)*
Fixed with a used needle in the past six months	2.3 (1.2–4.6)*	2.4 (1.2–4.8)*
Ever overdosed	2.6 (1.6–4.2)**	2.7 (1.6–4.5)**

UOR = unadjusted odds ratio; AOR = adjusted odds ratio; 95% CI = 95% confidence interval.

† Reference group includes all participants who were not removed from biological parents.

* $p < 0.05$; ** $p < 0.001$.

(AOR: 1.7, CI: 1.1–2.8); ever having self-harmed (AOR: 1.5, CI: 1.1–2.2); ever having attempted suicide (AOR: 1.4, CI: 1.0–2.1). Among participants who reported using injection drugs (Table 4), child welfare involvement was independently associated with: ever having overdosed (AOR: 2.7, CI: 1.6–4.5); ever having shared a used rig (AOR: 2.0, CI: 1.2–3.4); recent rig sharing (AOR: 2.4, CI: 1.2–4.8).

DISCUSSION

Indigenous leaders and scholars argue that the child welfare system in Canada has supplanted the residential school system as a means to dismantle Indigenous families and ways of life.[9,18] Consequently, they remain deeply concerned that the child welfare system contributes to ongoing health and social disparities among their young people.[15,18,19]

It is shocking that in this study involving young Indigenous people who use drugs, 65% had been taken into the child welfare system as children, with median age of first apprehension as young as 4 years old. Those in foster care were more than twice as likely to report intergenerational and present-day injustices, including having a parent who attended residential school and having been sexually abused as a child. As residential schools closed, the child welfare system stepped in to remove children from home environments deemed unfit due to poverty, substance misuse, neglect, violence and abuse.[8,20] Indigenous people who have aged out of the child welfare system are similarly monitored and at increased risk of having their own children apprehended.[20] Failures to provide supportive resources for Indigenous families that do not rely on removing children from homes remain a critical barrier to child protection, health and safety.[6] In particular, the funding model for Directive 20-1 is a significant barrier to providing culturally restorative child protection by delegated Aboriginal Agencies shown to be effective in other provinces.[21]

Child welfare involvement independently predicted self-harm, suicide ideation and attempt, and mental illness among young Indigenous people in this study. Indigenous scholars have described the intense psychological distress, cultural dislocation, identity confusion and emotional emptiness of young Indigenous people apprehended from their families and moved from home to home as wards of the state.[21] However, few studies have investigated cultural attachment requirements or long-term psychological and emotional ramifications of placements outside home communities for young Indigenous people in particular.[21] Of critical concern is the observed association between child welfare involvement and overdose among young people who used injection drugs in this study. Overdoses may be better understood as another way young Indigenous people attempt to end their own lives.[22] Suicide has reached crisis proportions among young Indigenous people in Canada, representing over one third of all deaths and occurring at five times the rate of suicide among non-Indigenous people.[23] Perhaps there is no greater evidence of the legacy of Canada's child welfare system than young Indigenous people's rejection of life itself.[24]

In this study involving young Indigenous people who use drugs, those who had been in child welfare were over twice as likely to be living with HIV. To our knowledge, this is the first study to

identify that systemic apprehension of Indigenous children has contributed to alarming levels of HIV vulnerability. However, involvement in child welfare was not associated with injection drug use or HIV infection among people who used injection drugs. Epidemiological data have demonstrated that the majority of HIV infections among Indigenous people in Canada are due to injection drug use.[16] This finding suggests that the early life experience of foster care is an important health determinant on the pathway to HIV vulnerability. Harm reduction programs often fail to take into account the ongoing impact of intergenerational trauma among young Indigenous people who use drugs in Canada. Programs aimed at reducing HIV risk must consider the mental, emotional, physical and spiritual impacts of child welfare involvement and the historical context in which the system exists.

Consistent with previous studies, involvement in the child welfare system was associated with homelessness later in life. The relationship between homelessness and foster care is complex and cyclical, exacerbated by poverty, substance use, and unresolved trauma. Unstably housed parents are often considered unfit to take care of children, resulting in apprehension of their children into the child welfare system.[12] Instability of foster care placements contributes to a feeling of "homelessness at home" for young people in care, helping to normalize housing insecurity and frequent moves.[25] Our findings suggest that over-representation of Indigenous young people among the homeless in Vancouver and Prince George may be related to the legacy of BC's child apprehension policies.[26,27]

Participants who had been in the child welfare system had greater odds of ever having been involved in sex work. It is distressing that 47.5% of participants who had been apprehended reported involvement in sex work prior to age 16. There is a paucity of research examining the relationship between involvement in child welfare, sexual risk, and sex work involvement among Indigenous young people. In BC, young Indigenous women are over-represented among people involved in sex work and face shocking levels of predation and violence, heightening risk for HIV infection.[28] Previous studies have underscored that for many young Indigenous people involved in sex work, post-traumatic stress stemming from early childhood and current violence often goes untreated.[29]

Limitations

Obtaining a representative sample of young vulnerable Indigenous people is challenging; however, community consultation and use of a variety of recruitment methods, including street outreach, has helped minimize selection bias. These findings do not necessarily extend to other Indigenous peoples elsewhere due to the diversity of Indigenous cultures, communities and experiences in relation to drug use. However, it should be noted that many Indigenous peoples around the world have faced mass removal of their children and are coping with similar health challenges as a result. Potential for socially desirable reporting has been addressed through repeated assurances of confidentiality and development of rapport between participants and Indigenous interviewers over time. Complex concepts under study may not be captured accurately with current instruments, such as details of child welfare system involvement, including length of stay and placement stability. Finally, due to the cross-sectional nature of the analysis, causation cannot be inferred. However, because the median age of first involvement in child welfare was 4 years old, it is unlikely that vulnerabilities explored in this study preceded that experience.

CONCLUSION

In conclusion, Indigenous leaders and scholars have repeatedly called for renunciation of current child welfare policies such as Directive 20-1 that continue to dismantle Indigenous cultural identity, families, and communities.[10,15,21] This study has found compelling evidence that young Indigenous people who use drugs in two cities in BC are experiencing distressing health outcomes associated with child welfare involvement, including HIV infection. Recommendations and child welfare protocols advocated by Indigenous scholars and child advocates must be implemented, including those that enable First Nations to exercise their inherent right to protect their own children.[30] Successful community-based models of child protection based on traditional teachings and customary care have been shown to address underlying familial issues while meeting the cultural needs of the child.[21] Indigenous leaders have recognized the importance of "culture as intervention" in addressing the impact of lifetime and intergenerational trauma, unresolved grief, and issues related to family separation.[31] Future research must involve young Indigenous people who use drugs and have been through the child welfare system in order to identify how to better support healthy attachments to families and communities.

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RÉSUMÉ

OBJECTIFS : Les dirigeants autochtones et les défenseurs des enfants et des familles sont profondément préoccupés par les effets du système de protection de la jeunesse sur la santé, notamment sur la vulnérabilité au VIH. Notre étude vise à décrire la prévalence de la prise en charge par un organisme de protection de la jeunesse et des vulnérabilités au VIH connexes chez les jeunes autochtones qui consomment de la drogue.

MÉTHODE : Le Cedar Project est une cohorte de jeunes autochtones de 14 à 30 ans consommant de la drogue à Vancouver et à Prince George (Colombie-Britannique). Un modèle de régression logistique multivariée a déterminé les associations entre les antécédents de prise en charge par un organisme de protection de la jeunesse et la vulnérabilité à l'infection à VIH.

RÉSULTATS : Sur 605 participants, 65 % avaient été retirés à leurs parents biologiques. L'âge médian à la première prise en charge était de 4 ans. Le fait d'avoir été victime d'agression sexuelle, d'avoir un parent ayant fréquenté un pensionnat et d'être séropositif pour le VIH étaient trois variables indépendamment associées à la prise en charge par un organisme de protection de la jeunesse. Les participants ayant été pris en charge par un organisme de protection de la jeunesse étaient aussi plus susceptibles d'avoir été sans abri, d'avoir été payés pour un rapport sexuel, d'avoir été diagnostiqués et hospitalisés pour une maladie mentale, de s'être automutilés, d'avoir songé au suicide et d'avoir fait une tentative de suicide. Parmi les participants utilisant des drogues par injection, ceux ayant été pris en charge par un organisme de protection de l'enfance étaient plus susceptibles d'avoir partagé des aiguilles et fait une surdose.

CONCLUSION : Nous avons des preuves convaincantes que dans deux villes de la C.-B., les jeunes autochtones qui consomment de la drogue présentent plusieurs résultats de santé troublants, notamment l'infection à VIH, associés à la prise en charge par des organismes de protection de la jeunesse. Il existe un besoin urgent d'amorcer des réformes du système judiciaire et d'établir des programmes éclairés par les traumatismes en utilisant la culture comme outil d'intervention.

MOTS CLÉS : protection de l'enfance; VIH; troubles liés à une substance; Indiens d'Amérique Nord