



Short communication

Prescription drug misuse among homeless youth



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ABSTRACT

Background: Prescription drug misuse (PDM) is highly prevalent among youth in the U.S., and can have serious health consequences. Homeless youth are a particularly vulnerable population with high rates of substance use. However, PDM has not been studied in a sample comprised exclusively of homeless youth. **Methods:** A sample of 451 homeless youth recruited from drop-in centers in Los Angeles, CA provided information on substance use, mental health, service utilization, trauma, and sexual risk behavior. Multivariable logistic regression assessed correlates of past month PDM.

Results: Nearly 50% reported lifetime PDM and 21.6% reported PDM in the past month. The most frequently used prescriptions in the past month were: opioids only (24.5%), sedatives only (23.4%), and stimulants only (10.6%); 14.9% used some combination of these three types of prescription medications. Homeless youth reported that prescriptions were most commonly obtained for free from friends or relatives (24.5%). Foster care involvement was associated with decreased PDM, while hard drug use, suicidal ideation, and unprotected sex were associated with increased PDM.

Conclusions: Homeless youth report high rates of PDM, and access these medications most frequently from friends and family. PDM among homeless youth clusters with other risk factors, including hard drug use, unprotected sex, and suicidal ideation. Surprisingly, foster care history was associated with decreased PDM. Programs aimed at preventing PDM among homeless youth should recognize the clustering of risk behaviors, assess prescription use/access when providing mental health services, and educate the general public about proper disposal of prescriptions.

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1. Introduction

Following marijuana, prescription drug misuse (PDM) is the second-most common form of illicit substance use among young adults in the U.S. (Substance Abuse and Mental Health Services Administration, 2012), with past month rates of 5.9% among metropolitan 18–25 year olds (SAMHSA, 2013). Lifetime rates of PDM among young adults range between 27.9% and 44.1% (Benotsch et al., 2013; Kelly et al., 2013). PDM can have serious health consequences, including heart failure, seizures, severe respiratory depression, and death (National Institute on Drug Abuse, 2011). Developmentally, youth may be at increased risk for suffering neurological and behavioral consequences from their PDM (Compton and Volkow, 2006).

Rates of substance use among homeless youth far exceed rates among their housed peers (Baer et al., 2003; Edidin et al., 2012; Gomez et al., 2010; Merscham et al., 2009; Milburn et al., 2006; Nyamathi et al., 2010; Thompson et al., 2010; Wenzel et al., 2010).

PDM may also be prevalent and problematic among homeless youth. However, very little research exists on PDM in this population. Existing research into PDM among homeless youth include a recent research brief by our study team, which found current PDM rates of 22% (Al-Tayyib et al., 2014). Among heterosexually-active adult homeless men, 26% reported any past year PDM (Rhoades and Wenzel, 2013), and among currently homeless injection drug users (IDUs), 11% reported past six month depressant or opioid PDM, respectively (Martinez et al., 2012).

The correlates of PDM have not been studied in a sample comprised exclusively of homeless youth. However, there is a large body of extant research on substance use among homeless youth that helps to provide a framework for the present investigation. Homeless youth with a history of foster care (Hudson and Nandy, 2012; Nyamathi et al., 2012), sexual abuse (Tyler and Melander, 2010), gang affiliation (Harper et al., 2008), early drug use initiation (Salomonsen-Sautel et al., 2008), who live on the street (Greene et al., 1997), who identify as a traveler (i.e., migratory homeless youth) (Martino et al., 2011), who report lower rates of self-reported physical health (Nyamathi et al., 2010), suicidal ideation (Unger et al., 1997), depression (Thompson et al., 2010; Unger et al., 1997), reduced emotional wellbeing (Nyamathi et al., 2010),

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posttraumatic stress disorder (PTSD; [Thompson et al., 2010](#)), self-injurious behavior, and low self-esteem ([Unger et al., 1997](#)) are more likely to use substances. Substance use among homeless youth has also been associated with exchange sex ([Walls and Bell, 2011](#)), having multiple sex partners, and engaging in unprotected sex ([Hollander, 2008](#)).

In prior research with non-homeless youth, PDM has been associated with depression ([McCauley et al., 2011](#); [Schepis and Krishnan-Sarin, 2008](#); [Zullig and Divin, 2012](#)), increased mental illness severity ([Lo et al., 2013](#)), suicidality ([Zullig and Divin, 2012](#)), trauma, stress, and PTSD ([Berenson and Rahman, 2011](#)), early sexual debut ([Berenson and Rahman, 2011](#)), unprotected sex ([Benotsch et al., 2011](#); [Johnson et al., 2013](#)), and engaging in sex under the influence of alcohol or drugs ([Benotsch et al., 2011](#)). Research among homeless adult men found increased PDM among those with symptoms of PTSD ([Rhoades and Wenzel, 2013](#)).

The use of other substances is also likely to be associated with PDM. Prescription drugs may be substituted for unavailable or expensive hard drugs, or may be used to increase the effects of other illicit drugs ([Inciardi et al., 2007](#); [Lankenau et al., 2012b](#)). Among adolescents and young adults, using alcohol, binge drinking, marijuana, crack/cocaine, methamphetamine, ecstasy, heroin, and inhalants have all been associated with PDM ([Berenson and Rahman, 2011](#); [Jones, 2013](#); [Lankenau et al., 2012a](#); [Lo et al., 2013](#); [McCabe et al., 2009, 2006](#); [McCauley et al., 2011](#); [Schepis and Krishnan-Sarin, 2008](#)).

This paper will first present a profile of PDM among a sample of homeless youth utilizing drop-in centers in the Los Angeles area, including types of prescription drugs being misused and the most frequent ways in which prescriptions were obtained. Subsequent analyses will examine the demographic, mental health, sexual risk, and non-prescription substance use correlates of PDM among homeless youth.

2. Methods

2.1. Study

As part of a longitudinal panel study of homeless youth utilizing drop-in centers in Los Angeles, CA, interviews were completed with a single panel of 451 youth interviewed in November–December, 2012 (Venice, CA) and January–February, 2013 (Hollywood, CA); of these, 435 youth provided information on PDM. All youth utilizing services at the two drop-in centers during data collection periods were invited to participate. Response rates were 77.2% in Venice and 75.3% in Hollywood. Signed informed consent was obtained from youth 18 years of age and older and informed assent was obtained from youth 13–17 years of age. Data were collected by self report and via an audio computer-assisted self interview (ACASI) for those with low literacy. Participants received \$20 in cash or gift cards as compensation for their time. This study was approved by the Institutional Review Board at the authors' university, and the researchers obtained a Certificate of Confidentiality from the National Institutes of Health.

2.2. Measures

2.2.1. PDM and other substance use

Adapted from the [Centers for Disease Control and Prevention, 2011](#) Youth Risk Behavior Survey (CDC's YRBS; CDC, 2011), participants were asked for both lifetime and the past 30 days: "How many times have you taken a prescription drug without a doctor's prescription or used more of the drug or took the drug more often than prescribed? Prescription drugs may include OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax". Respondents identified the type of prescription drug (i.e., stimulants, sedatives,

and/or opioids) with a question adapted from the National Institute on Drug Abuse's modified ASSIST (2012), and identified how and where they had obtained prescriptions they misused using a question adapted from the 2010 National Survey on Drug Use and Health ([United States Department of Health and Human Services, 2010](#)). Using items adopted from the YRBS (CDC, 2011), we assessed for past 30 day frequency of binge drinking and marijuana use, and adapted this question format to assess for past 30 day frequency of cocaine, crack, heroin, meth, ecstasy, and injection drug use.

2.2.2. Demographic and homeless characteristics

All demographic information was based on self-report. Youth indicated whether they were currently a traveler (defined as "someone who moves by themselves or with friends from city to city after a short period of time"). Living situation was assessed by asking youth to indicate where they were currently staying, with response options adapted from [Tsemberis et al. \(2007\)](#).

2.2.3. Service utilization and mental health

Two items assessed youths' frequency of past month utilization of therapy/counseling or healthcare services (from "every day or almost every day" to "not at all this month"), dichotomized to indicate service use. Symptoms of PTSD were assessed with the Primary Care PTSD (PC-PTSD) screener ([Prins et al., 2003](#)). Depressive symptoms were measured by the 10-item Center for Epidemiological Studies Depression Scale (CES-D; [Kohout et al., 1993](#)). An adopted YRBS item assessed for suicidal ideation. Suicidal ideation assessment time periods were different for respondents taking the survey for the first time and those completing follow-up surveys; as such, 66% of respondents' suicidal ideation reports are for the past year and 34% are for the past six months. Lifetime experiences of trauma were assessed using statements from the UCLA PTSD Index for the DSM-IV ([Steinberg et al., 2004](#)).

2.2.4. Sexual risk behavior

Respondents indicated the types of sexual activity they engaged in during their last sexual encounter. Response options included "anal sex, no condom/bareback" and "vaginal sex, no condom," dichotomized to indicate unprotected anal/vaginal sex. Items adapted from the YRBS (CDC, 2011) assessed for engaging in vaginal or anal sex under the influence of alcohol or drugs at last sexual encounter, age of sexual debut, and the number of anal and vaginal sex partners in the past 30 days. Lifetime history of exchange sex was assessed with: "Have you ever exchanged sex (oral, vaginal, or anal) for money, drugs, a place to stay, food or meals, or anything else?"

2.3. Analytic methods

Pearson's chi-square tests were used to test for statistically significant univariable relationships between past month PDM and categorical variables, while two-tailed, independent group *t*-tests were used to examine statistical significance between PDM and continuous measures. Adapting model-building techniques suggested by [Hosmer and Lemeshow \(2000\)](#), all variables associated at the univariable level with PDM at $p < 0.10$ were included in a multivariable logistic regression model assessing past month PDM (with demographic controls). Nearly all measures of substance use were statistically significantly associated with PDM at the univariable level, and current use of methamphetamine, cocaine, crack, heroin, ecstasy, and injection drugs were all highly correlated. To avoid multicollinearity, a single variable indicating use of any of these substances in the previous 30 days ("hard drug use") was created. Analytic *N*s vary based on single-item non-response. All analyses were completed in STATA 12.0 (StataCorp, College Station, TX).

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