12 Back to the Future for Canada's National Anti-Drug Strategy: Homeless Youth and the Need for Harm Reduction

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Introduction

The landscape of national drug policy has changed significantly in Canada over the past ten years. In 2003, reducing alcohol and drug related harm was a national priority. Accordingly, Canada's Drug Strategy (CDS) had, "the stated aim of reducing the harm associated with alcohol and other drugs to individuals, families, and communities" (PHAC, 2003:n.p.). Further, the CDS explicitly endorsed initiatives such as, "needle exchange, methadone maintenance, [and] abstinence-oriented treatments such as therapeutic communities" (PHAC, 2003:n.p.). In 2005, Health Canada co-authored a report that established a national framework for action to reduce the harms associated with drugs and alcohol in Canada. The authors wrote,

> *At the core of this document is a collective conviction that a national framework for action to reduce the harms associated with alcohol and other drugs and substances is necessary, practical and – most of all – achievable. These goals can be attained through dedication and the sharing of expertise, experience, ideas and perspectives.* (Health Canada and Canadian Centre on Substance Abuse [CCSA], 2005:3)

Shortly after releasing this report, the Conservative government withdrew their support for the initiative (Webster, 2012). Just two years later, in October 2007, Canada's Drug Strategy was replaced by the new (but arguably not improved) National Anti-Drug Strategy (NADS). The NADS is comprised of a three-part action plan focusing on prevention, treatment, and enforcement (Government of Canada, 2011). However, in none of these areas is harm reduction included in the plan. The Centre for Addiction and Mental Health (CAMH, 2008) has criticized the federal government for this omission, arguing that through this shift in policy the federal government is out-of-step "with drug strategies across Canada", and that, "[s]everal cities and provinces in Canada, including Victoria, Vancouver, Edmonton, London, Toronto, and Ottawa," have implemented harm reduction programs and in many cases included harm reduction in their municipal and/or provincial drug strategies.

This chapter argues that in order to align itself with many of these municipal approaches, Canada's federal government needs to return to the days when harm reduction was a national priority. As a public health initiative, harm reduction is a particularly important approach to promoting the safety and well-being of marginalized substance users, and especially those who are young, homeless, and/or otherwise street-involved. I begin this chapter by briefly discussing harm reduction and identifying some of its defining characteristics. I then shift the focus to a study conducted in Ottawa, Ontario, in which street youth and social service providers were asked to share their views on the harms associated with substance use among homeless young people. I end by arguing that addressing these harms requires a harm reduction approach. Therefore, I call on the federal government to reinstate harm reduction as one of the pillars of its national drug strategy.

The Key Characteristics of Harm Reduction

Harm reduction has been a part of Canada's Drug Strategy since 1992 (Office of the Auditor General of Canada, 2001), but in more recent years support for it has steadily declined at the federal level under Prime Minister Stephen Harper's Conservative government (Webster, 2012). In Canada, as in other parts of the world, harm reduction remains a controversial issue (Erickson & Hathaway, 2010). While harm reduction has many supporters, as a strategy that does not rely strictly on abstinence, it faces resistance from those who fear it will lead to widespread drug legalization (Wodak & Saunders, 1995) and those who feel it is condoning and/or facilitating substance use (Single, 1995). Hwang (2006) argues that these reservations might be lessened if there were greater recognition that harm reduction strategies are meant to complement and not replace more traditional approaches.

Part of the resistance to harm reduction also emerges, at least in part, from the lack of a universally agreed upon definition. As researchers at the Centre for Addiction and Mental Health (2009) note, harm reduction is too dynamic and broadly applied to allow for (or require) the creation of a standardized definition. Yet, through the efforts of researchers, community activists, and policy makers, some defining features have remained relatively stable. For instance, in an early (and well cited) definition, Single (1995) writes that harm reduction involves, "[a] policy or programme directed towards decreasing adverse health, social, and economic consequences of drug use even though the user continues to use psychoactive drugs at the present time" (289). In 2002, seven years later, researchers offered a similar definition that focuses on reducing the personal and social harms caused by drug use regardless of whether the person continues to use substances. These researchers define harm reduction as,

> *...a set of strategies and approaches aimed at reducing the risks and harmful effects associated with substance use, and addictive behaviours, for the person, the community and society as a whole. While helping users abstain from substances or addictive behaviours is one appropriate long-term goal for some, harm reduction strategies place the emphasis on the most immediate achievable and positive changes whether or not they are shown to reduce use.* (Anne Wright and Associates Inc., 2002:4)

Today this definition of harm reduction remains relatively stable. As researchers note, most people would agree that at the core, "[h]arm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use" (CAMH, 2009:n.p.).

In Canada, members of the Canadian Centre on Substance Abuse's National Policy Working Group have come together to establish specific criteria that researchers, activists, and policy makers can use to define harm reduction. Through their efforts they identified five principles, including: pragmatism (being realistic and practical), humane values, focus on harms, balancing costs and benefits, and the priority of immediate goals (Beirness et al., 2008). Harm reduction, while originating in the long tradition of public health, has also more recently become recognized internationally as a social justice issue, based on demanding respect for substance users (Stimson & O'Hare, 2010). To this end, significant progress has been made internationally in adopting harm reduction initiatives (Pauly, 2008).

However, while harm reduction has been embraced by many nations worldwide (including Canada for a period), in recent years Canada has begun to revoke national support for these policies and programs (Webster, 2012). Just

two examples are the recent (unsuccessful) attempt to withdraw funding for Vancouver's safer injection facility, Insite, and the (successful) removal of funding for safer tattooing programs in federal prisons (Webster, 2012). This lack of support is harmful for individuals and communities who rely on and benefit from harm reduction initiatives. Not least among those affected by this decreased support are street-involved youth, who often engage in substance use with harmful effects. The rest of this chapter discusses a small qualitative study in which homeless youth and social service providers in Ottawa were asked to share their views on the harms associated with substance use by homeless youth and the need for harm reduction programs to help lessen these effects.

Methodology

The interviews for this study were conducted in the summer of 2006 in Canada's national capital region, Ottawa, Ontario. This context is significant. Exactly one year prior, in the summer of 2005, the Mayor of Ottawa brought together a large network of service providers, academics, business leaders, media representatives, and special interest groups to develop a comprehensive drug and alcohol strategy within the City of Ottawa (Community Network for the Integrated Drugs and Addictions Strategy [CNIDAS], 2006). The result, the Ottawa Integrated Drugs and Addictions Strategy, was designed as a reflection of the existing national drug strategy, founded on the four pillars of prevention, treatment, harm reduction, and enforcement (CNIDAS, 2006). However, while there was support for harm reduction at the city level, the year 2005 was also when the conservative federal government withdrew support for harm reduction initiatives following the national framework report co-authored by Health Canada (Webster, 2012). While still recognized as a part of Canada's Drug Strategy, harm reduction was quickly losing support and would be removed as a national pillar just one year after the interviews, in 2007 (Government of Canada, 2011).

The participants in this study all lived (at least temporarily) in the Ottawa region and were very aware of the political tensions surrounding harm reduction initiatives. As part of a broader study, ten homeless youth and nine social service providers participated in structured interviews that lasted approximately 30 to 90 minutes. The participants were selected through a convenience sampling method, as each either worked at or was a client within a particular social service agency that offered harm reduction programs. The six male and four female youth were all self-identified substance users between the ages of 16 and 24. At the time of the interviews they were all living either on the street, in shelters, or temporarily with friends. The majority had been without stable housing on-and-off for several years. The three male and six female social service providers were selected based on their range of experience and positions within the agency.

Three had advanced degrees and relatively extensive experience working with street youth, having been employed at the agency from five to ten years. The remaining six providers were less experienced with homeless and at-risk populations, having worked for the agency between one and ten months. All providers actively administered the harm reduction services offered through the agency.

The purpose of the project was to examine the substance use behaviours of homeless youth in Ottawa and to better understand at what point they – and social service providers – believed substance use became problematic. Throughout the interviews, the nineteen participants discussed the most common substances used by homeless youth living in Ottawa, the reasons for using, and the harmful effects substance use can have for the user, as well as for others. Based on this data, I argue the importance of harm reduction initiatives for reducing these negative consequences.

Substance Use in Ottawa

According to Paul, a 23 year old homeless man living in Ottawa, he and his friends use drugs and alcohol, “morning, afternoon, and night.” “Street youth,” he continues, “we do it whenever we can get it. If it’s four o’clock in the morning, we do it. If it’s four o’clock in the afternoon, we do it.” While not all homeless young people use drugs and alcohol, research has consistently shown that a sizable portion do, at least on occasion (Baron, 1999; Boivin et al., 2005; Karabanow, 2004; Hagan & McCarthy, 1997; Roy et al., 1998). In a multi-year, multi-site study with homeless youth, the Public Health Agency of Canada [PHAC] (2006) found that in 2003, 26.9% of participants reported drinking alcohol more than once per week and 36% reported alcohol intoxication in the previous 3 months. Additionally, more than 95% reported injection and/or non-injection drug use in their lifetime (PHAC, 2006).

More recent research conducted in Toronto shows that youth often have preferred substances (Barnaby et al., 2010). In Ottawa, marijuana was generally considered to be the preferred substance, which is not surprising given that the PHAC (2006) study also found that 78.3% of street youth in various Canadian cities reported marijuana use. The regularity with which it was used meant that service providers and youth alike had become used to it and regarded its use without alarm. For instance, Dawn, a service provider with ten years’ experience, stated that,

> *Clearly practically all of them use marijuana and I almost think in this day and age that marijuana isn’t so much of a problem or an issue. It isn’t something that has to be addressed with any sort of strength. It’s just the bottom line for most young people and certainly for many people on the street.*

Alcohol was also recognized as a commonly used substance in Ottawa, as similarly found in other Canadian research studies conducted around the same time (Agboola, 2005, Bodnarchuk et al., 2006). Like marijuana, alcohol use in itself was not considered problematic, but rather a socially acceptable and legal option for these youth (even though many were under the legal drinking age). When asked why young people choose to use alcohol, Lisa, an experienced social service provider said, "I think that it's easier to obtain. It's a very socially accepted thing to do, to get drunk." Karen, a young homeless woman, added that, "Some people don't want to do drugs because they think it damages your mind and everything, and you still have to fill that space with something. So, like, everyone has their addiction and alcohol is a legal one."

In addition to marijuana and alcohol, participants also noted that crack-cocaine, ecstasy, and morphine were preferred substances of street youth living in Ottawa. In the PHAC (2006) multi-site study, these substances were reportedly used by a minority of respondents as well. Of the participants who reported non-injection drug use 5.8% used crack-cocaine and 5.1% used ecstasy in the past 3 months (PHAC, 2006). Additionally, 34.4% of injection drug users reported morphine use in the 3 months before the study. Also mentioned, but believed to be less commonly used in Ottawa, was crystal methamphetamine. Conversely, other Canadian studies have found methamphetamine to be more commonly used than crack and ecstasy by street youth (Bodnarchuk et al., 2006; PHAC, 2006).

Many adolescents, whether housed or homeless, experiment with substances (Adlaf et al., 2005), often for entertainment (Hagan & McCarthy, 1997) and because they like the way it makes them feel. In the interviews these reasons arose frequently. For instance, social service provider Natalie stated these youth, "really like the buzz," and Paul, a homeless young man noted that he and his peers use drugs, "because it feels good." On the street, as among housed youth, there may be peer pressure to conform. For instance, Chris, a young homeless man, admitted, "Sometimes I do it because everybody else is and I don't want to be the outcast." This pressure is something the social service providers have noticed as well, with Susan and Dawn respectively saying, "I've seen some youth sort of wanting to fit in," and "They just want to be part of what's going on, part of the youth scene."

However, while many young people use substances because of their social nature and pleasurable benefits, those who are homeless also often report using them to cope with the pressures and loneliness of street life, to add meaning to their days, and as a means of self-medicating against mental illnesses (Karabanow, 2004). The unfortunate outcome is that underlying issues such as loneliness, boredom, and mental illness are not addressed and the substances used to cope with these stressors can actually contribute to making them worse. The worse the problems

become, the more the youth may turn to substance use to cope. This can lead to a pattern of on-going – and potentially increasingly harmful – substance use.

The Harmful Cycle of Substance Use

The harmful effects of substance use will often vary depending on the specific substance used (Barnaby et al., 2010). In this study, however, participants were asked to speak about the harmful effects of substance use more generally. Among the Canadian population, substance use related harms have primarily been recognized in three ways – loss of workplace productivity, economic and social burdens on the health care system, and the financial costs of law enforcement (Rehm et al., 2006). In 2002, the overall cost of substance abuse in Canada was estimated to be $39.8 billion dollars, with productivity losses accounting for 61% of this cost, health care for 22.1%, and law enforcement for 13.6% (Rehm et al., 2006). The harmful effects of substance use for homeless youth, while specific to this population, can also be categorized in these three ways.

Loss of Productivity

The loss of productivity was found to be the greatest economic harm among the general Canadian population, accounting for a loss of $24.3 billion in 2002 (Rehm et al., 2006). As many homeless youth are not employed in the formal economy (Gaetz & O'Grady, 2002; Gaetz et al., 1999) the loss of productivity cannot be measured in the same way. According to Natalie, a social service provider, homeless youth "don't have those responsibilities yet and they can just go out and be frivolous and drink up a storm and be hung over the next day and still function." However, while they may be able to function in some tasks, like squeegeeing and panhandling, the use of substances may interfere with the achievement of longer-term goals such as obtaining stable housing, continuing their education, and/or securing formal employment[1].

According to a recent study in Vancouver, street-involved youth who use substances reported feeling unsupported in their efforts to find housing (Krüsi et al., 2010). For many homeless youth, the use of drugs and alcohol can make it difficult to move off the street. Joe, for instance, a young homeless man, stated that substance use "becomes a big circle of not being able to get anywhere. It's just a cycle of stuckness because you're using, you're all high and you're obviously not on topic or not

1. It should be noted that the use of drugs and alcohol is not the only barrier to the realization of short and long term goals among homeless youth. Many lack the education, stability, and resources needed to obtain formal, well-paying employment. For many, the only alternatives are low wage, menial jobs that are undesirable and may offer little or no benefit to youth above what they gain from the informal economy. For more detailed arguments, refer to Gaetz & O'Grady (2002) and Karabanow et al., (2010).

on the ball." The use of substances other than alcohol or marijuana has been linked to housing instability (Tevendale et al., 2011), as has injection drug use (Rhule-Louie et al., 2008). Substance use can be harmful for youth because, as social service provider Helen stated, long-term use often "starts interfering with obligations."

On-going substance use can impair judgement and reduce the motivation needed to achieve long term goals like obtaining housing, returning to school, and/or finding employment. However, it can just as easily interfere with the fulfilment of more immediate and pressing needs like finding food. This is especially troubling given that research consistently shows homeless individuals, including youth, suffer from nutritional deficiencies (Dachner et al., 2009; Gaetz et al., 2006; Khandor & Mason, 2007; Tarasuk et al., 2005; Tarasuk et al., 2010). The youth in this study noted that money that could be spent on essentials like food and clothing often goes toward substance use instead. Max, a 17 year old homeless man, explained,

> *Every pay cheque you get $200 bucks, you're buying, you know, a half ounce of weed. There goes $180 bucks and then you're spending the last $20 on some more weed...And that goes every week and you're still doing it and every penny you get, you're spending it on weed...You stop caring what's in your fridge, what you need to eat. It's just pure weed.*

Karen, a homeless young woman, conveyed a similar message. When asked how she would define problematic substance use, she suggested it occurs when drugs become a substitute form of financial currency. Karen stated,

> *Actually for me, it's when everything that you see, like a soda would be like, "I could buy a joint with that. That's a joint." When you start to use drugs as currency. Everything that you could buy or spend your money on, you see it as, like, how much drugs you could buy for it, you know. Yeah, if I can spend $10 on something I'm like, "Well that's a whole length." I'll see that as 'not-drugs'.*

What these comments show is that some young people trade their labour for the ability to purchase drugs. In this sense productivity is directed away from the achievement of long term goals and the fulfilment of daily human needs in order to engage in substance use. Unfortunately this can perpetuate a dangerous cycle. Many young people find life on the street boring, which makes working toward affording drugs and alcohol a fulfilling task. Most, or all, of the money they earn goes toward purchasing drugs and alcohol, leaving them unable to fulfil short and long term needs. Once the substances are gone the cycle begins again. Shane, a young homeless man who was caught in this cycle, discussed how people can become dependent on it for survival. When asked why he uses drugs he responded:

> *To add meaning to life. 'Cause if you don't have a job or like, goals in the future, you need to at least have a goal...make money for something, like, short-term. So, everyday you need to make like $20 to get [drugs]... so there's, like, some strive for life, maybe if you're lacking a reason to live.*

The use of drugs and alcohol shifts the kinds of productivity young people engage in from more formal economic activities to the pursuit of substances and substance use. The outcome is often a cycle in which time, money, and energy are directed away from longer-term goals like obtaining housing and employment and shorter-term needs like purchasing food, while furthering the need to pass one's days with something else – a void often filled by substance use.

Health and Mental Health Care

In 2002, substance abuse cost Canadians $8.8 billion in health care spending (Rehm et al., 2006). Even without the use of substances, homelessness has consistently been linked to poor physical and mental health. Common problems that have been documented include foot problems, scabies and body lice, dental diseases (Hwang, 2001), hunger and food deprivation (Dachner et al., 2009; Gaetz et al., 2006; Khandor & Mason, 2007; Tarasuk et al., 2010), post-traumatic stress disorder (Bender et al., 2010), and loneliness (Rokach, 2005), among others. The immediacy of meeting daily needs like obtaining food, shelter, and safety often takes precedence over health (O'Connell, 2004). Even when health problems do become pressing, those who are homeless often experience difficulty accessing health care, due to the lack of a health card (Khandor & Mason, 2007), a sense of being unwelcome in health care settings (Wen et al., 2007), and an inability to pay for and/or store prescribed medication (Hwang & Gottlieb, 1999).

The use of substances can compound existing problems and make the physical and mental health of homeless individuals even worse (Karabanow et al., 2007). Their inability or reluctance to access health care services may suggest they are not burdening the health care system (Rehm et al., 2006), but deteriorating physical and mental health can be particularly problematic for individuals who experience them. Joe, a twenty-four year old man who had been on the street since age sixteen, suggested that "ill health" is "a major thing" in relation to substance use, adding, "especially when you start getting close to my age there, [and into] your late twenties. You start getting really unhealthy to the point where it's time to stop, or you're not making it out of your thirties." Inadequate coping strategies and perceived poor health have both been linked to high drug use among homeless youth (Nyamathi et al., 2010). These negative effects may be worsened by high risk substance use behaviours, such as sharing needles (PHAC, 2006; Roy et al., 2002) and/or unsafe sex practices like forgoing condom use (Halcon & Lifson, 2004; Tucker et al., 2011).

Many young people on the street suffer from mental health disorders such as depression, schizophrenia, post-traumatic stress disorder, and bipolar disorder (Bender et al., 2010; Boivin et al., 2005; Merscham et al., 2009). Street youth often meet the criteria for dual or multiple diagnoses, and in particular concurrent or overlapping disorders (Johnson et al., 2005; Kirst et al., 2011; Slesnick & Prestopnik, 2005). For many young people on the street substance use is a way of coping with the effects of these disorders through self-medicating instead of seeking professional treatment (Karabanow, 2004; Karabanow et al., 2007). Max, a young homeless man in Ottawa, explained, "You're depressed, you get drunk, and it just takes everything off your mind." Likewise, Molly, a young homeless woman stated, "I use drugs to hide the pain...because when you use drugs you don't feel the pain."

There is a sense of stigma attached to being both homeless (Thompson et al., 2006) and a substance user (Singer, 2006). This stigmatization increases the risk that these young people will experience low self-esteem, loneliness, thoughts of suicide, and feelings of being trapped (Kidd, 2007). Substance use can help decrease the intensity of these feelings, as Natalie, a social service provider, suggested, "A lot of drug use is a coping mechanism to deal with their life as it is right now." However, there is again the risk of getting caught in a cycle. As Susan, another service provider, noted about her agency's clients, "We have a lot of youth that their drug consumption has led to mental health issues, which becomes a vicious circle...because they just end up using more and then the problem gets worse and they're not getting treated." Young people may choose to use drugs and alcohol in order to cope with their poor physical health and the psychological difficulties of living on the street. However, this approach often results in greater harm, as the substance use only masks the problems instead of addressing them and may even lead to a worsening of the conditions themselves.

Law Enforcement

The third largest cost associated with substance abuse in Canada in 2002 was the financial burden on law enforcement agencies, accounting for $5.4 billion (Rehm et al., 2006). In order to survive on the street young people sometimes engage in illegal activities (Hagan & McCarthy, 1997) and the participants in this study suggested that substance use contributes to such behaviour. Jeff, a social service provider, observed, that

> *Street violence is on the rise, there's no doubt about it. Does alcohol or drugs have something to do with this? I don't know for sure, but I think it'd be stupid to say it doesn't. Something is going on with drugs and alcohol and violence.*

Jeff's suspicion is confirmed by research that shows that homeless youth who meet the criteria for substance abuse disorders (i.e., alcohol abuse, alcohol dependence, drug abuse) may be more likely to engage in violence (Crawford et al., 2011). This study also indicated that men are more likely to be involved in violence than women (Crawford et al., 2011), which supports the observations of Beth, a sixteen year old runaway who stated, "Fights happen. When guys drink, not all of them, but I find that most of them become violent...They're happy until someone says, 'get out of my way'...then it's like, 'excuse me?' kind of thing and they get violent."

When under the influence of drugs and/or alcohol homeless youth may engage in violent behaviour, but the use of these substances also increases the risk that they will be victimized. In one study, Kirst et al., (2011) found that street-involved youth with concurrent or overlapping mental health problems were nearly four times more likely to have been victimized in the previous twelve months. Laura, a young woman in Ottawa, told of her experience of victimization while under the influence of drugs. She stated, "Back in the summer I was beaten-up by drunk kids for no reason. So, after that I had a new view on drugs and alcohol and I started to get off of it. At the time I was on ecstasy." In this incident both Laura and the offenders were under the influence. Unfortunately, research indicates that homeless youth are a highly victimized population and that they are unlikely to report incidents to the police (Gaetz, 2004; Gaetz et al., 2010).

The financial cost to law enforcement generally does not arise from youth reporting substance-related crimes committed against them. Rather, these costs emerge from ticketing these youth and from calls initiated by the general public. A recent study conducted in Toronto highlights the degree to which homeless youth are treated as disorderly persons and subjected to zero-tolerance measures like ticketing and criminalization (O'Grady et al., 2011). The use of substances in public is a common reason young people come into contact with the police. Lucas, a social service provider in Ottawa, explained, "If numerous people are consuming drugs or alcohol in a public place, because most of them are homeless, that's against the law so a lot of times people are issued tickets." The resulting costs are financial (to the youth, but also to the law enforcement agency), legal (as youth are threatened with jail or other action if the tickets go unpaid), and social (as these young people become burdened with outstanding debt that interferes with their ability to get off the streets and obtain credit for long term goals like housing) (O'Grady et al., 2011).

Law enforcement officials may also become involved with homeless youth as a result of calls placed by the general public. Young people under the influence of substances may commit crimes directed at housed persons, as when property is stolen to pay for drugs and/or alcohol. Paul, a young man in Ottawa, suggested

that substance use becomes harmful, "when that's all they think about. When it's all they want to do...They want to break into housing to steal nice items to pawn, to get the money." The general public may also call emergency services out of concern for the welfare of substance users. According to social service provider Jeff, "When Joe Citizen sees someone passed out, their natural reaction is to call 911...This generates a 911 call, which means fire, ambulance, and police [will show up]...which costs about $1,600...It's a lot of money." Although the figure Jeff offers is unverified, his point remains valid. At a cost of $5.4 billion (Rehm et al., 2006), a substantial amount of Canadian funds are being directed toward law enforcement efforts that address problematic substance use.

Harm Reduction in Canada: Back to the Future

Many homeless youth use drugs and/or alcohol, often with harmful consequences for themselves and others. Frequently these harms are part of a cycle in which substance use becomes the way of coping with stressors on the street while at the same time contributing to, and possibly worsening, them. Because youth get caught in this cycle, where substance use fulfils an important role in their daily lives, quitting does not feel like a viable option. Marlatt and Witkiewitz (2010) suggest that harm reduction can act as a safety net for substance users like these youth. In the course of their lives, they write, users will come to an intersection marked by a traffic light. More traditional approaches, like rehabilitation centres, may treat the light as though there were only two settings: red (stop using) or green (keep using). However, traffic lights also have a third option, Marlatt and Witkiewitz (2010) note. They may be yellow, signalling the person to slow down, take precautions, and notice the potential harms that may arise from crossing the intersection. In their analogy, harm reduction is the yellow light that keeps users relatively safe when they are unable or unwilling to see the light as red.

In the introduction to this chapter I presented a quote from a Health Canada report that outlined a national framework for addressing the harms related to alcohol and drug use. It stated that a framework of this kind was "necessary, practical and – most of all – achievable" (Health Canada and CCSA, 2005:3). The authors of this report wrote that programs that recognize the realities of adolescent substance use and that focus on reducing the potential for harm are more likely to succeed than programs that focus on abstinence alone (Health Canada and CCSA, 2005) because they recognize that substance use may fulfil many roles in the user's life. In the time since this report was published there have been significant changes to national drug policy. Canada's Drug Strategy has been replaced by Canada's National Anti-Drug Strategy (NADS).

The findings of this research study show the harms that can result for homeless

young people, and others, as a result of substance use. Many rely on drugs and/or alcohol to give their days a sense of purpose, to pass the time, to provide entertainment, and to cope with the stressors of life on the street. For these reasons, it may be difficult for young people who are homeless to stop using altogether. These findings point to the need for some pressing policy-based decisions. First and foremost is the need for harm reduction to be reinstated as a national priority. If refraining from using is not a possible option for all young people, then something must be done to lessen the harmful effects.

The National Treatment Strategy Working Group (2008) has called for a population-informed response, in which services and supports are tailored to the risk factors, prevalence and severity of use, and the unique characteristics of substance use among specific populations. For homeless youth, this could include services such as the distribution of supplies like clean needles, crack kits, and condoms both in service agencies, as well as through outreach to locations where young people spend time. Further, young people should have access to education, through pamphlets and posters, workshops, and informal discussions, about how to use more safely. This education could include factors such as not sharing needles, not using while alone, identifying the signs of an overdose, and always practising safe sex, even while under the influence of drugs or alcohol. As a strategy for homeless young people, harm reduction has many benefits because it acknowledges, and addresses, the many complicated reasons these youth use substances.

Increasingly, harm reduction has become a staple in the management of problematic substance use for high-risk populations (Erickson & Hathaway, 2010) and in particular for young people who are on the streets (Poulin, 2006). Marlatt and Witkiewitz (2010) note that "The primary goal of most harm-reduction approaches is to meet individuals where they are at and not to ignore or condemn the harmful behaviors, but rather to work with the individual or community to minimize the harmful effects of a given behavior" (593). As such, harm reduction is largely about having respect for the user. Pauly (2008) notes that within a harm reduction context, respect for persons stands in sharp contrast to the disrespect often associated with the stigma of drug use. Unlike moral arguments that may enhance the user's sense of shame, guilt, and stigmatization, harm reduction is humanistic and based on principles of acceptance (Marlatt & Witkiewitz, 2010). Harm reduction aims to empower individuals by treating them with respect and acceptance as they currently are, and not based on an idea of what others think they should be.

Harm reduction programs promote a non-judgemental and non-stigmatizing environment while also offering a way for homeless youth to work collaboratively with one another (Poland et al., 2002; Weeks et al., 2006) and with so-

cial service providers (Merkinaite et al., 2010). Their involvement can create a community of practice (a process of sharing information and experiences that allows members to learn from each other, and have an opportunity for growth and development) centred around harm reduction (Buccieri, 2010). Such a community may build relationships between young people and social service providers that are more balanced and empowering for the youth (Rogers & Ruefli, 2004). Equally important, accessing harm reduction services can bring hard-to-reach and marginalized youth into contact with social service agencies and provide them with access to treatment and other essential supports, like health care and meal programs (Laurie & Green, 2000; Poulin, 2006).

The costs of substance abuse in Canada are high (Rehm et al., 2006) and the federal government should be applauded for trying to create a strategic response. However, the omission of harm reduction as a key piece of this response is striking (CAMH, 2008). When it comes to addressing the substance use practices of homeless youth, the National Anti-Drug Strategy falls short. The prevention and treatment action plans state that the federal government will enhance, provide, and enable treatment and support programs for young people who are at risk for drug use while supporting research on new treatment methods (Government of Canada, 2011). Rather than funding a search for new treatment methods, federal resources would be better spent on funding harm reduction-based research and program initiatives. This kind of action would be a step forward in supporting our nation's homeless youth, who, as high-risk substance users, are arguably among the most in need of a strategic, organized response. In order to send a clear message of support, the federal government of Canada needs to take a step back in time, to when harm reduction was a priority, in order to create a better future.

References

Adlaf, E. M., Begin, P., & Sawka, E. (Eds.). (2005). *Canadian addiction survey: A national survey of Canadians' use of alcohol and other drugs: Prevalence of use and related harms: Detailed report.* Ottawa: Canadian Centre on Substance Abuse.

Agboola, Y. (2005). Enhanced Surveillance of Canadian Street Youth. Ottawa: Public Health Agency of Canada.

Anne Wright and Associates. (2002). *A recommended approach to supporting learning and knowledge development with those who work with people who are homeless and using substances.* Ottawa: Ottawa Working Group on Addictions in the Homeless Population, & Supporting Community Partnerships Initiative.

Barnaby, L., Penn, R., & Erickson, P. G. (2010). *Drugs, homelessness & health: Homeless youth speak out about harm reduction.* The Shout Clinic harm reduction report, 2010. Toronto: Shout Clinic.

Baron, S. W. (1999). Street Youths and Substance Use: The role of background, street lifestyle, and economic factors. *Youth & Society*, 31(1), 3-26.

Beirness, D. J., Jesseman, R., Notarandrea, R., & Perron, M. (2008). *Harm reduction: What's in a name?* Ottawa: Canadian Centre on Substance Abuse.

Bender, K., Ferguson, K., Thompson, S., Komlo, C., & Pollio, D. (2010). Factors associated with trauma and posttraumatic stress disorder among homeless youth in three U.S. cities: The im-

portance of transience. *Journal of Traumatic Stress,* 23(1), 161-168.

Bodnarchuk, J., Patton, D., & Rieck, T. (2006). *Adolescence without shelter: A comprehensive description of issues faced by street youth in Winnipeg.* Retrieved from Addictions Foundation of Manitoba website: http://afm.mb.ca/About%20AFM/documents/StreetYouthReport.pdf

Boivin, J. F., Roy, E., Haley, N., & Galbaud du Fort, G. (2005). The health of street youth: A Canadian perspective. *Canadian Journal of Public Health,* 96(6), 432–437.

Buccieri, K. (2010). Harm reduction as practice: Perspectives from a community of street youth and social service providers. *Social Development Issues,* 32(3), 1-15.

Centre for Addiction and Mental Health. (2008). *The national anti-drug strategy: A CAMH response.* Retrieved from http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/public_policy_submissions/national_drug_policy/Documents/NADS%20Response%20Final%202008.pdf

Centre for Addiction and Mental Health. (2009). *CAMH and harm reduction: A background paper on its meaning and application for substance use issues.* Retrieved from http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/public_policy_submissions/harm_reduction/Pages/harmreductionbackground.aspx

Community Network for the Integrated Drugs and Addictions Strategy. (2006). Report to health, recreation and social services committee: Integrated drug strategy – terms of reference. Retrieved from city of Ottawa website: http://www.ottawa.ca/calendar/ottawa/citycouncil/hrssc/2006/02-16/ACS2006-CCS-HRS-0002%20E.htm#_ftn4

Crawford, D. M., Whitbeck, L. B., & Hoyt, D. R. (2011). Propensity for violence among homeless and runaway adolescents: An event history analysis. *Crime & Delinquency,* 57(6), 950-968.

Dachner, N., Gaetz, S., Poland, B., & Tarasuk, V. (2009). An ethnographic study of meal programs for homeless and under-housed individuals in Toronto. *Journal of Health Care for the Poor and Underserved,* 20(3), 846-853.

Erickson, P. G., & Hathaway, A. D. (2010). Normalization and harm reduction: Research avenues and policy agendas. *International Journal of Drug Policy,* 21, 137–139.

Gaetz, S. (2004). Safe streets for whom? Homeless youth, social exclusion, and criminal victimization. *Canadian Journal of Criminology and Criminal Justice,* 46(4), 423-455.

Gaetz, S., & O'Grady, B. (2002). Making money: Exploring the economy of young homeless workers. *Work, Employment and Society,* 16(3), 433–456.

Gaetz, S., O'Grady, B., & Buccieri, K. (2010). *Surviving crime and violence: Street youth and victimization in Toronto.* Toronto: Justice for Children and Youth; Homeless Hub.

Gaetz, S., O'Grady, B., & Vaillancourt, B. (1999). *Making money: The Shout Clinic report on homeless youth and employment.* Toronto: Central Toronto Community Health Centres.

Gaetz, S., Tarasuk, V., Dachner, N., & Kirkpatrick, S. (2006). 'Managing' homeless youth in Toronto: 'Mismanaging' food access and nutritional well-being. *Canadian Review of Social Policy,* 58, 43-61.

Government of Canada. (2011). *National Anti-Drug Strategy.* Retrieved from http://www.nationalantidrugstrategy.gc.ca

Hagan, J., & McCarthy, B. (1997). *Mean streets: Youth crime and homelessness.* Cambridge: Cambridge University Press.

Halcon, L. L., & Lifson, A. R. (2004). Prevalence and Predictors of Sexual Risks Among Homeless Youth. *Journal of Youth and Adolescence,* 33(1), 71-80.

Health Canada, & Canadian Centre on Substance Abuse. (2005). *Answering the call: National framework for action to reduce the harms associated with alcohol and other drugs and substances in Canada* (1st ed.). Retrieved from http://www.nationalframework-cadrenational.ca/images/uploads/file/ccsa0113232005_e.pdf

Hwang, S. W. (2001). Homelessness and health. *Canadian Medical Association Journal,* 164(2), 229-233.

Hwang, S. W. (2006). Homelessness and harm reduction. *Canadian Medical Association Journal,* 174(1), 50-51.

Hwang, S. W., & Gottlieb, J. L. (1999). Drug access among homeless men in Toronto. *Journal of the Canadian Medical Association,* 160(7), 1021.

Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2005). Substance abuse disorders among homeless and runaway adolescents. *Journal of Drug Issues,* 35(4), 799–816.

Karabanow, J. (2004). *Being young and homeless: Understanding how youth enter and exit street life.*

New York: Peter Lang.

Karabanow, J., Hopkins, S., Kisely, S., Parker, J., Hughes, J., Gahagan, J., & Campbell, L. A. (2007). Can you be healthy on the street?: Exploring the health experiences of Halifax street youth. *The Canadian Journal of Urban Research,* 16(1), 12-32.

Karabanow, J., Hughes, J., Ticknor, J., Kidd, S., & Patterson, D. (2010). The economics of being young and poor: How homeless youth survive in neo-liberal times. *Journal of Sociology and Social Welfare,* 37(4), 39-64.

Khandor, E., & Mason, K. (2007). *The street health report 2007.* Toronto: Street Health.

Kidd, S. A. (2007). Youth homelessness and social stigma. *Journal of Youth and Adolescence,* 36, 291-299.

Kirst, M., Frederick, T., & Erickson, P. G. (2011). Concurrent mental health and substance use problems among street-involved youth. *International Journal of Mental Health and Addiction,* 9(5), 543-553.

Krüsi, A., Fast, D., Small, W., Wood, E., & Kerr, T. (2010). Social and structural barriers to housing among street-involved youth who use illicit drugs. *Health & Social Care in the Community,* 18(3), 282-288.

Laurie, M. L., & Green, K. L. (2000). Health risks and opportunities for harm reduction among injection-drug-using clients of Saskatoon's needle exchange program. *Canadian Journal of Public Health,* 91(5), 350–352.

Marlatt, G. A., & Witkiewitz, K. (2010). Update on harm-reduction policy and intervention research. *Annual Review of Clinical Psychology,* 6, 591-606.

Merkinaite, S., Grund, J. P., & Frimpong, A. (2010). Young people and drugs: Next generation of harm reduction. *International Journal of Drug Policy,* 21, 112–114.

Merscham, C., Van Leeuwen, J., & McGuire, M. (2009). Mental health and substance use indicators among homeless youth in Denver Colorado. *Child Welfare,* 88(2), 93–110.

National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a national treatment strategy.* Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada. Retrieved from http://www.nationalframework-cadrenational.ca/uploads/files/TWS_Treatment/nts-report-eng.pdf

Nyamathi, A., Hudson, A., Greengold, B., Slagle, A., Marfisee, M., Khalilifard, F., & Leake, B. (2010). *Journal of Child and Adolescent Psychiatric Nursing,* 23(4), 214-222.

O'Connell, J. J. (2004). Dying in the shadows: The challenge of providing health care for homeless people. *Journal of the Canadian Medical Association,* 170(8), 1251-1252.

Office of the Auditor General of Canada. (2001). *Report of the auditor general of Canada on illicit drugs: The federal government's role.* Ottawa: Government of Canada. Retrieved from http://www.oag-bvg.gc.ca/internet/docs/0111ce.pdf

O'Grady, B., Gaetz, S., & Buccieri, K. (2011). *Can I see your ID? The policing of youth homelessness in Toronto.* Toronto: Justice for Children and Youth; Homeless Hub.

Pauly, B. (2008). Harm reduction through a social justice lens. *International Journal of Drug Policy,* 19(1), 4-10.

Poland, B. D., Tupker, E., & Breland, K. (2002). Involving street youth in peer harm reduction education: The challenges of evaluation. *Canadian Journal of Public Health,* 93(5), 344–348.

Poulin, C. (2006). Harm reduction policies and programs for youth. Canada: Canadian Centre on Substance Abuse.

Public Health Agency of Canada. (2003). *Harm reduction and injection drug use: An international comparative study of contextual factors influencing the development and implementation of relevant policies and programs.* Retrieved from http://www.phac-aspc.gc.ca/hepc/pubs/hridu-rmudi/canada-eng.php

Public Health Agency of Canada. (2006). *Street youth in Canada: Findings from enhanced surveillance of Canadian street south, 1999-2003.* Retrieved from http://www.phac-aspc.gc.ca/std-mts/reports_06/pdf/street_youth_e.pdf

Rehm, J., Baliunas, D., Brochu, S., Fischer, B., Gram, W., Patra, J., . . . Taylor, B. (2006). *The costs of substance abuse in Canada 2002 highlights.* Ottawa: Canadian Centre on Substance Abuse.

Rhule-Louie, D. M., Bowen, S., Baer, J. S., & Peterson, P. L. (2008). Substance use and health and safety among homeless youth. *Journal of Child and Family Studies,* 17(3), 306-319.

Rogers, S. J., & Ruefli, T. (2004). Does harm reduction programming make a difference in the lives

of highly marginalized drug users? *Harm Reduction Journal,* 1(7). doi: 10.1186/1477-7517-1-7

Rokach, A. (2005). Private lives in public places: Loneliness of the homeless. *Social Indicators Research,* 72(1), 99-114.

Roy, E., Haley, N., Leclerc, P., Cedras, L., & Boivin, J. F. (2002). Drug injection among street youth: The first time. *Addiction,* 97(8), 1003-1009.

Roy, E., Lemire, N., Haley, N., Boivin, J. F., Frappier, J. Y., & Claessens, C. (1998). Injection drug abuse among street youth: A dynamic process. *Canadian Journal of Public Health,* 89(4), 239–240.

Singer, M. (2006). What is the "drug user community"? Implications for public health. *Human Organization,* 65(1), 72–80.

Single, E. (1995). Defining harm reduction. *Drug and Alcohol Review,* 14(3), 287–290.

Slesnick, N., & Prestopnik, J. L. (2005). Dual and multiple diagnoses among substance using runaway youth. *The American Journal of Drug and Alcohol Abuse,* 31(1), 179–201.

Stimson, G. V., & O'Hare, P. (2010). Harm reduction: Moving through the third decade. *International Journal of Drug Policy,* 21(2), 91–93.

Tarasuk, V., Dachner, N., & Li, J. (2005). Homeless youth in Toronto are nutritionally vulnerable. *The Journal of Nutrition,* 135(8), 1926-1933.

Tarasuk, V., Dachner, N., Poland, B., & Gaetz, S. (2010). The "hand-to-mouth" existence of homeless youths in Toronto. In J. D. Hulchanski, P. Campsie, S. Chau, S. Hwang, & E. Paradis (Eds.), *Finding home: Policy options for addressing homelessness in Canada* (Rev. ed.). Toronto: Cities Centre, University of Toronto.

Tevendale, H. D., Comulada, W. S., & Lightfoot, M. A. (2011). Finding shelter: Two-year housing trajectories among homeless youth. *Journal of Adolescent Health,* 49(6), 615-620.

Thompson, S. A., McManus, H., Lantry, J., Windsor, L., & Flynn, P. (2006). Insights from the street: Perceptions of services and providers by homeless young adults. *Evaluation and Program Planning,* 29(1), 34–43.

Tucker, J. S., Ryan, G. W., Golinelli, D., Ewing, B., Wenzel, S. L., Kennedy, D. P., . . . Zhou, A. (2012). Substance use and other risk factors for unprotected sex: Results from an event-based study of homeless youth. *AIDS and Behavior,* 16(6), 1699-1707.

Webster, P. C. (2012). The redlining of harm reduction programs. *Canadian Medical Association Journal,* 184(1). doi:10.1503/cmaj.109-4054

Weeks, M. R., Dickson-Gomez, J., Mosack, K. E., Convey, M., Martinez, M., & Clair, S. (2006). The risk avoidance partnership: Training active drug users as peer health advocates. *Journal of Drug Issues,* 36(3), 541–570.

Wen, C. K., Hudak, P. L., & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. *Journal of the Society of General Internal Medicine,* 22(7), 1011-1017.

Wodak, A., & Saunders, B. (1995). Harm reduction means what I choose it to mean. *Drug and Alcohol Review,* 14(3), 269–271.