



Drugs, Homelessness & Health: Homeless Youth Speak Out About Harm Reduction

The Shout Clinic Harm Reduction Report, 2010



Art work by L.P.

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The Shout Clinic Harm Reduction Report, Toronto: January 2010

Authors:

Lorraine Barnaby, Rebecca Penn and Patricia G. Erickson, Ph.D.

Research Team:

Lorraine Barnaby, Principal Investigator (Health Promoter, Shout Clinic), Patricia G. Erickson, Ph.D., Co-Investigator (Senior Scientist, Centre for Addiction and Mental Health), Tara Fidler, Data Analyst (University of Toronto), Val Fuhrmann, Peer Researcher (Shout Clinic), Matt Johnson, Peer Researcher (Shout Clinic).

Design and Layout:

Lorraine Barnaby

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Shout Clinic
467 Jarvis Street
Toronto, ON M4Y 2 G8
(416) 927-8553

www.ctchc.com
info@ctchc.com
lbarnaby@ctchc.com

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2010, Drugs, Homelessness & Health: Homeless Youth Speak Out About Harm Reduction. The Shout Clinic Harm Reduction Report, 2010

DEDICATION

This Report is dedicated to all of the youth who participated in this study

And in remembrance of those who are no longer with us

Table of contents

About Shout Clinic	6
Harm Reduction Principles	7
Preface - Susan Sheppard	8
Executive Summary	9
Background: Homeless Street-Involved Youth and Substance Use	11
Study Methods: About the Shout Clinic Harm Reduction Needs Assessment	14
<u>About Survey Respondents</u>	20
Demographics	20
Income	21
<u>Homelessness and Housing</u>	24
Age of first Experience of Homelessness	24
Sources of Shelter	25
Homeless and Housing Issues	28
<u>Substance Use</u>	30
Age of first use	30
Substance Use History: Frequency of Use	33
Methods of Substance Use	36
Reasons for Using Substances – Roles and Reasons	38
Places Where Youth Use Substances	40
Who Youth Use Substances With	43
Knowledge of Safer Drug Use Practices	44
<u>Substance Use Related Harms and Risks</u>	45
Injection Related Harms and Risks	45
Poly Drug Use	46
Sharing Substance Use Equipment	46
Use of Homemade and Toxic Pipes	49
Harms Associated with Crack and Methamphetamine Use	50
Where Youth Get Harm Reduction Supplies	51

Personal Strategies to Reduce Risks	52
<u>Conflicts With the Law</u>	54
History of Imprisonment	54
Policing Issues	55
<u>Social Stigma: Attitudes Toward Youth Who Use Substances</u>	58
<u>Health Issues</u>	60
Physical Health	60
Mental Health, Trauma and Stress	62
Where Youth Get Their Primary and Mental Health Care	65
Dependency and Addiction	67
Sexual Activities and Condom Use	68
<u>Barriers to Harm Reduction, Primary Health Care and Community Services</u>	72
Policy Barriers	73
Structural Barriers	74
Attitudinal Barriers	77
Knowledge Barriers	80
Complex and Multi-Dimensional Barriers	80
<u>Conclusion & Recommendations:</u>	82
For all Service Providers and Sectors	84
For Harm Reduction and Public Health Professionals, and Youth	85
For Addiction and Harm Reduction Professionals	89
For Mental Health Professionals	90
For Community Health Services	92
For Municipal and Provincial Governments	93
For Police	94
Appendix 1	95
References	100
Acknowledgements	102
<u>Sketch Art Work:</u>	cover page and pages 24, 56, 67 and 71

ABOUT SHOUT CLINIC

Shout Clinic opened in July 1992 as a result of concerns expressed by community agencies about the health of homeless and street-involved youth, and the difficulties these youth had in accessing mainstream health providers.

Shout Clinic is a comprehensive health service for homeless and street-involved youth ages 16 and under 25 years of age living in the GTA. The main purpose of Shout Clinic is to increase the accessibility of health care to an under-served and marginalized youth population. Most of the energy of Shout Clinic is focused on direct comprehensive social and health care for street youth. Clinic staff works to decrease barriers in traditional health care agencies, and assist other street youth serving agencies to promote the health of our clients.

Shout Clinic's interdisciplinary team includes physicians, nurses, mental health counsellors, a health promoter, a pregnancy and parenting worker, a dental assistant, an intake worker, client support worker/medical secretaries, and administrative staff. Partner organizations provide the following on site services and supports: legal advice, chiropody, employment information, housing assistance, access to identification.

Shout Clinic also have a free on-site dental clinic (staffed by volunteer dental staff), a harm reduction distribution program, a client advisory committee and bursary awards. In order to address accessibility issues, we offer satellite clinics in drop-in centers where nurses can meet youth in settings which are familiar and, by working together with other staff, a broader range of services can be offered to young people whose needs are very complex.

Our Mission

Shout Clinic delivers primary, interdisciplinary care to youth ages 16 to 24 years through a trauma informed and harm reduction philosophy. We provide a safe, respectful and inclusive approach both within our health centre and in the community.

Our Vision

Shout Clinic will enhance the resilience, health and well being of marginalized street involved and/or homeless youth from diverse communities. We aspire to address the determinants of health and to advocate for social justice and equity through collaborative community engagement. We are committed to being an effective, innovative and accountable community health centre.

Our Values

Shout Clinic values achievement of excellence in the delivery of our services. The values that define who we are and the services we provide include:

- Client Rights and Social Justice
- Diversity
- Integrity
- Non Judgmental
- Respect
- Self Determination
- Voluntary
- Youth and Community Engagement

PRINCIPLES OF HARM REDUCTION

Harm Reduction is a term that defines policies, services, programmes, practices, values and approaches that work to reduce substance related health, social and economic harms and risks to individuals, communities and society without necessarily requiring abstinence.

Factors which contribute to substance related harms and risks:

- Actions and choices of individuals
- The environment in which people use substances
- The laws and policies designed to control drug use

Harm reduction recognizes the value and dignity of all human beings. It recognizes the right for comprehensive, non-judgemental medical and social services and the fulfillment of basic needs of all individuals and communities. It also recognizes the competency of individuals to make their own choices and changes in their lives and provides options to support this competency.

Harm reduction:

- Sees substance use as a health issue not a moral or criminal one
- Does not promote or condemn drug use
- Meets people where they are at
- Is user-centred and user driven
- Is pragmatic - stresses short-term and achievable objectives
- Is evidence based and cost effective
- Considers non-use a viable choice

There are several components to a comprehensive harm-reduction approach for at risk and marginalized groups of people who use drugs. They include but are not limited to:

- On-site and mobile harm reduction distribution programs (e.g. needle exchanges)
- Access to safer drug use equipment (e.g. injection equipment), safer sex supplies, body art supplies (e.g. safer body piercing kits) and biohazard containers for safe disposal of used equipment
- Safe injection and consumption sites
- Overdose prevention and treatment (e.g. Naloxone treatment)
- Methadone maintenance and drug substitution; and other different models of treatment programs
- Outreach, education, counselling and health promotion aimed at maintaining and enhancing health and well-being; and the prevention of substance use related harms
- Peer programming, support groups and user unions for people who use substances
- The provision of medical and mental health services
- Access to basic needs such as food, clothing, drinking water, and shelter/housing
- Referrals to shelters, housing, health care, counselling, detoxification, drug treatment, vocational and other services and programs
- The inclusion of people who use substances in the design and planning of harm-reduction programs, strategies and policies; and drug law reforms
- Advocacy, policy development and law reform

For additional information visit the International Harm Reduction Association at:

<http://www.ihra.net/>

PREFACE

Drugs, Homelessness & Health: Homeless Youth Speak Out About Harm Reduction (2010)

Youth who are homeless in Toronto face many challenges, from meeting basic needs to navigating our complex service system, to finding housing and other supports to help stabilize their lives. These challenges are further complicated for youth who use alcohol or other drugs as they often face discrimination from service providers because of their substance use further marginalizing them from the very supports they need.

The Shout Clinic has a long history of providing services to youth who are not well served by the rest of the service system. As part of these efforts, the Shout Clinic has conducted a comprehensive new study that provides important information about the health needs and issues of Toronto youth who are homeless and use drugs. This research reinforces the critical role of harm reduction and other health and social services in supporting youth who are homeless, and recommends strategies to reduce barriers and improve access. The report also highlights the commitment that young people have to improving their own health and well being; a strength we need to build on.

The voices of youth are central to this report as they are the best storytellers of their own lives and experiences. The voices are clear and candid, creative and courageous. These are the voices that governments, funders, policy makers and service providers must listen to if we want to make progress in improving the lives and brightening the futures of this under-served group of youth in our community.

Susan Shepherd
Manager, Toronto Drug Strategy Secretariat
Toronto Public Health, City of Toronto

EXECUTIVE SUMMARY

The purpose of the report is to present the results of a harm reduction needs assessment survey among the most at-risk homeless youth in Toronto, identify barriers to appropriate health services, and based on the youth's voices, make recommendations, and advocate for better programs to serve this vulnerable population.

The study was designed with three components. First we surveyed 100 poly-substance using homeless youth screened for recent (past 6 month) histories of crack (n=71), methamphetamine (n=51), non-prescribed opioid (n=53) and/or injection drug use (n=33). Then, based on the survey results, we conducted five focus groups with 27 street-involved youth to discuss their reactions to the survey findings; these groups provided many quotes on various topics. As well, four young people took part in an arts-involved segment, creating pictures of street life used to illustrate this report. The survey sample of 100 street-involved youth consisted of 75 young men, 21 young women and 4 transgendered/transsexual individuals aged 16 to 25, the majority of whom were in the older age range. Nine out of ten were Canadian born and nearly 2/3 identified their ethno-racial background as White/Caucasian.

- Nearly half of the survey participants had experienced homelessness before their 16th birthday. In the past six months, they reported staying in a wide variety of places for at least one night; these included (from most to least frequent) hostels, friends' place, rented accommodation, streets/alleys, hotels, jail or police station, parks, stairwells and abandoned buildings. Safety issues were a major concern for all these youth.

- Youth reported using a wide variety of opioids, stimulants and hallucinogens in the past six months. Other than significantly higher rates by women for oxycontin, Tylenol with codeine and fentanyl, there were only small differences between male and female levels for all other substances.
- Nevertheless, when asked for a drug of choice, 27 of the 100 youth surveyed preferred cannabis and 8 chose alcohol. Other favourites were crack, powder cocaine or amphetamine, selected by 12 youth each, and heroin by 10 individuals. The remaining participants listed a wide array of substances as their drug of choice
- The surveyed youth were familiar with many modes of administration of substances, including smoking in pipes or other devices such as tin foil or light bulbs, snorting, swallowing, various forms of injection and anal suppositories. Of the 33 participants with injection experience, for 18% this occurred when they were 13, 14 or 15 years old. Currently, 39% were daily injectors while the rest did so less frequently.
- The locations where youth took drugs reflected their sources of shelter and social networks. While an indoor location, particularly a private one such as someone's home, was preferred, all youth at some time had smoked, snorted or injected drugs in a public location such as a club, institution or laundromat, or outdoors in a park, street, or stairwell.
- About 70% of youth rated their knowledge (gained from a wide variety of sources) of safer drug use practices, including injection techniques, as excellent or good. More participants had shared snorting devices (59%) than needles (21%) or other injection equipment (36%). Sharing pipes to smoke methamphetamine was particularly prevalent – 81% had done so. While these figures indicated that many youth do practice safer drug use some of the time, they also identified a number

of factors associated with the homeless situation that impeded safe practices.

- While needle and syringe exchange services do provide safe injection equipment, even if not always accessed, safer devices to limit the harms of smoking drugs have much more limited availability, and the use of homemade and toxic pipes for smoking crack and methamphetamine was widespread.
- The youth were asked to provide details about their access to harm reduction supplies. On-site or mobile needle exchange programs, which often supplied safer crack kits as well as clean injection equipment, were the most frequent source. Others mentioned included friends, sex partners, drug dealers, pharmacy, and strangers. Participants also emphasized that who was providing the supplies was important, preferably someone they knew and felt comfortable with, whether a pharmacist or a peer outreach worker.
- Not surprisingly, half of those surveyed had been imprisoned in the past year, and most had interactions with the police, some reporting positive and some negative experiences. For the latter, a frequent complaint was the police taking away safe drug use supplies.
- While 29% of survey respondents reported being physically or sexually assaulted in the past 6 months, only one third received any medical treatment or counselling.
- Youth were acutely aware of the social stigma attached to homeless youth, and also felt it was exacerbated by their identification as drug users. This made it even more difficult to see a hopeful future for themselves.
- Many health issues were identified by youth, with only half (52%) rating their physical health as excellent or good. Even less, 35% rated their mental and emotional health as excellent or good. Not surprisingly, many forms of health care were accessed by youth in the past six months: ER, community health centres, walk-ins, and individual physicians.

Barriers:

When asked to identify barriers they had experienced obtaining both harm reduction services and health care in general, the survey and focus group participants provided a long list of structural and individual factors. The barriers youth perceived related to policies, practices and programs included hours, location, eligibility, waiting lists, and lack of program options. Key to these issues was the absence at the federal and some local levels of recognition of the importance and need for harm reduction to serve this high-risk group, despite an overall Four Pillar approach adopted by the city of Toronto.

More personal barriers articulated by youth were their lack of knowledge of safer drug use practices and where to obtain appropriate services. They also recognized that the instability of their lives, especially their lack of housing, militated against their planning of day-to-day activities, practicing self-care and their ability to look to their future.

Recommendations:

The participants in both the survey and the focus groups were asked to put forward recommendations and these are recorded at length, in their own words, at the end of this report. Some are more feasible than others, cost issues did not go unrecognized, but all were expressed with insider knowledge of what steps might be taken to improve the present conditions and provide a more hopeful future for street-involved youth.

Finally, the overarching conclusion is that based on the acceptance of harm reduction principles, it is crucial to provide services geared to this homeless, high-risk, drug-using population. As evident in this report's findings, homeless youth run the same high risks as adults. In addition, the extra vulnerability due to their age places an expectation on public health services, not the criminal justice system, to meet these needs. Protecting youth with harm reduction services rather than punishing them should be the priority for future programs.

BACKGROUND AND LITERATURE REVIEW

INTRODUCTION: IMPORTANCE OF THIS PROJECT

In Canada as elsewhere, and particularly in urbanized areas where street youth congregate, recourse to a wide range of legal and illegal substances is a persistent feature of the homeless existence (Adlaf et al., 1996; Johnson et al., 2005). Substances may be used for many of the same reasons as youth in general - for recreation and pleasure, peer group acceptance, being part of a social group, coping with the various challenges of everyday life - and survival. Substance use, particularly if it involves the most dangerous drugs such as crack and methamphetamine and/or progresses to injection drug use, may increase the risks of other problems. These include acquiring an infectious disease, drug dependencies, sexual exploitation, drug overdose, discrimination, criminal involvements, escalated police attention, and violence related to the drug trade (Baron, 1999; Roy et al., 2004; Strike et al., 2001). Many drug-involved street youth end up working in the sex trade and/or with long term homelessness (Erickson et al., 2000; Haley & Roy, 1999). The greater the number of substances consumed by the youth, often accompanied by the more dangerous modes of administration, the greater the risk for drug-related harms, including various physical health problems and comorbidity with mental health disorders (Johnson et al., 2005; Kipke et al., 1997).

SUBSTANCE USE PATTERNS AMONG HOMELESS YOUTH AND RELATED HEALTH RISKS

While the majority of adolescents in Canada and the United States experiment with alcohol and other drugs (Adlaf et al. 2005; Johnston et al., 2002), street-involved youth use more substances, earlier and more often, than their housed counterparts (Johnson et al., 2005; Smart et al., 1992). While alcohol and cannabis are generally widespread in this age group, rates of heavier and more frequent use of both are found among homeless youth, with levels of past year use exceeding 80% (Adlaf et al., 1996). In domiciled youth, use of other illicit substances such as cocaine, crack, opiates, and amphetamines rarely exceeds 5%, while these may more commonly reach levels of 30-40% among street-involved youth (Adlaf et al., 1996; Johnson et al., 2005). Homeless youth's use of multiple substances, as well as greater frequency of use, places them at elevated risk for health problems such as substance dependence, infectious diseases, drug overdose and victimization.

Among homeless youth, prior research has indicated that levels of alcohol and drug use are quite similar for boys and girls, though this varies somewhat by the location and time of the study. In Toronto, Adlaf et al. (1996) found that male street youth were more likely to use LSD, speed and inhalants than females, and Dematteo et al. (1999) also found that females were less likely to take drugs; another study reported that female street youth were more likely to use methadone and other prescription drugs than men (Youthlink, 2003). More recently, Kirst, Erickson and Strike (2009) found higher rates of recent alcohol and marijuana use among males, but no sex differences for any other substances or for number of drugs used; additionally, poly-substance use was associated with poor mental health among the girls and poor physical health among the boys. Roy et al. (2004) in Montreal found that males were more likely to inject drugs but females were more likely to die of a drug overdose. While trend data are difficult to collect, given the transient nature of this population, there is some evidence that poly-

substance use is increasing among the homeless, with new street drugs adding to rather than replacing the types of drugs available from the illicit drug market (Haley and Roy, 1999; Smart et al. 1992; Youthlink, 2003).

Health problems related to substance use by street youth may take various forms. Among the most serious are overdose resulting in hospitalization or death, and the transmission of infectious diseases such as HIV and Hepatitis C through shared injection equipment or other paraphernalia (Dematteo et al., 1999; Roy et al., 2004). Other health effects of drug use leading to diseases may be through prostitution and sexual coercion that involves payment for drugs or drug intoxication to facilitate unwanted sexual activity (Dematteo et al., 1999; Strike et al., 2001). Since female street youth are more likely than male street youth to be involved in the sex trade and other sexual services in exchange for food and shelter, their increased vulnerability is greater. Some evidence shows that female drug injectors are at greater risk for infectious diseases due to pressure through their social networks and partner relationships (Choi et al. 2006; Riehm et al. 2004; Bruneau et al. 2001; Spittal & Schechter 2001).

Another potential risk for substance-using homeless youth is the development of drug dependencies and other substance use problems. These have been investigated by Adlaf et al (1996) in Canada and Kipke et al. (1997) and Johnson et al. (2005) in the United States who found that high rates of multiple dependencies and problems were evident. For example, Johnston et al. (2005) reported that nearly two-thirds of homeless adolescents met lifetime criteria for at least one substance disorder, for alcohol or other drugs, and nearly all of these also displayed at least one other mental disorder (based on the DSM III-R diagnostic interview). In this study, males were significantly more likely than females to be diagnosed with a substance disorder. Adlaf et al (1996) asked street youth about alcohol and drug problems such as being hospitalized, being the object of others' concern, or feeling they had a problem, and no differences by sex were found,

except for drug-related arrests (an indirect effect) being more common for males. However, they noted that the number of drugs used was significantly higher for males.

Risk of violent victimization is a daily fact of life on the street. In Toronto, Gaetz (2004) found that 92% of the male and 77% of the female street youth reported at least one incident of being the victim of a crime in the past year, compared to national rates of about 40% for the 15-24 year old age group. Rates were similar for victimization in the crimes of assault, theft, vandalism of personal property and illegal entry of household property, but for robbery, male rates were twice as high (45% vs. 23%); females were more than twice as likely to report sexual assault (51% vs. 19%). While it is not possible to conclude that substance use may have rendered the youth more vulnerable to certain forms of victimization, Gaetz did find a clear relationship for those involved in drug dealing: 85% were victims of crime. Other studies have similarly suggested that youth involved in drug dealing may both be more violent towards others and be more likely to be victimized through robbery of their drugs or money (Baron, 1999)

CORRELATES OF SUBSTANCE USE PROBLEMS AMONG HOMELESS YOUTH:

Research has shown that poor physical and mental health, history of maltreatment, housing instability, peer relationships, and involvement in criminal activity are related to substance use problems among at-risk and street-involved youth (Baron 1999; Bousman et al. 2005; Van Leeuwen et al. 2004; Erickson & Butters 2005; Harrison, Erickson, Korf et al. 2007; Adlaf, Zdanowicz & Smart 1996; McCaskill et al. 1998; Ennett et al. 1999). For example, in his study of 200 male street youth, Baron (1999) reported that parental substance use history, peer influence, history of physical abuse, involvement in property crime and drug dealing, and depression were predictive of heavier use of different types of drugs. Among a sample of homeless youth in San Diego, peer influence and parental monitoring were

predictive of substance use (Bousman et al. 2005). Similarly, another US study found that homeless youth who had an alcohol or illicit drug user in their social network were more likely to use alcohol and drugs (Ennett et al. 1999). An early study of 217 street youth in Toronto (Adlaf et al. 1996) showed that family history of alcohol and drug problems, frequency of drinking alcohol, and length of time on the street were predictive of increased number of drugs used.

In summary, while considerable literature has examined substance use among homeless and street-involved youth, there is a clear need for more research on the most at-risk youth who are extensively poly-substance involved, who inject drugs or engage in other unsafe practices, and who rarely show up in treatment programs designed for adults. In addition, little evidence is available on the perceptions of homeless youth themselves on available services and the barriers and resistance to their access. If some of the most serious mental and physical health consequences are to be averted, it is essential to determine the best ways to present harm reduction programs that homeless youth themselves will find attractive and useful.

STUDY METHODS

Research Objectives

This research was conducted to: (1) identify the current substance use, harm reduction and sexual practices and health status of homeless street-involved youth who use substances in the Greater Toronto area (GTA); (2) identify the needs, gaps, and barriers in current harm reduction services, resources, and the advocacy for community members; (3) advocate and influence stakeholders' response to the emerging issues and needs of community members; and (4) determine the direction and nature of Shout Clinic's harm reduction programming. This research was carried out from September 2008 to June 2009, and hence presents a recent picture of the health status of a segment of the homeless population that is heavily involved in substance use and related risks.

Sample size

The exact number of homeless youth living in Toronto is unknown. In the City of Toronto, it is estimated that 20,000 youth used Toronto emergency shelters in 2003. In the same year, 27% of all shelter users were youth¹. Some 6,200 children's (14 years of age and under) first experience of homelessness was with their family, which may be a precursor to youth homelessness in the future². It is estimated that roughly 65,000 youth are homeless or living in homeless shelters throughout the country at some time during the year³.

To participate in the needs assessment activities, youth must meet the project's eligibility criteria. We set our target sample size at 100 participants for the survey, 24 participants for the three focus groups and four individuals for the arts-informed

component. This sample size allowed us to present a wide range of statistical descriptions (e.g., perceptions of harm reduction needs and gaps examined in relation to age, gender, homeless status, drug use history, and health status). In total, 100 youth participated in the survey/interviews, 27 youth then participated in the focus groups; we conducted a total of five focus groups, and 4 youth participated in the arts-informed component.

Eligibility

This project specifically targeted high-risk, substance-using, homeless street-involved youth between the ages of 16-24 years living in Toronto. This target group represents an extremely vulnerable population that exhibit a variety of high-risk behaviours associated with their substance use, including sexual practices, involvement with sex work and the drug-trade industry, and high rates of imprisonment. They also experience increased risk due to environmental factors such as unsafe or no housing, poverty, violence, sexual assault, discrimination, social isolation, and barriers to social and health services.

Survey interview, focus group and the arts-informed project participants were screened on the basis of their substance use history and living situation. Those eligible had to have used crack, methamphetamine, an opioid (not medically prescribed), and/or injected any drug in the past 6 months. Additionally, all had to have been absolutely homeless at some time in the past 6 months, defined as living on the street, in a squat, in a shelter or staying with friends. The following two tables display the breakdown of the respondents' ages and their use of crack, methamphetamine, opioids and the injection of drugs; and their poly drug use in the past six months. The data presented are based on 100 completed survey interviews.

¹Toronto Youth Profile 2003, City of Toronto, 2003

² Environmental Scan on Youth Homelessness, Canadian Mortgage and Housing Corporation, 2001

³ CBC: The fifth Estate – No Way Home – March 10, 2004

Respondents' ages and screening question

Age Groups	Crack (n=71)	Meth ⁴ (n=51)	Opioids (n=53)	IDU ⁵ (n=33)
16 to 18 years	9	11	9	4
19 to 21 years	26	19	17	17
22 to 24 years	34	20	24	11
25 years ⁶	2	1	3	2

Screening Question – Poly Substance Use Past 6 Months

Substance	Crack (n=71)	Meth ⁴ (n=51)	Opioids (n=53)	IDU ⁵ (n=33)
Crack		61%	74%	76%
Meth ⁴	44%		45%	52%
Opioids	55%	47%		76%
IDU ⁵	35%	33%	47%	

Of the 100 survey respondents, 75% were male, 21% female and 4% identified as transgender/sexual. The majority of those taking part in the survey fell in the 19 - 24 age range (8 individuals had just turned 25 years of age prior to their participation). Nearly 2/3 (63%) identified their ethno-racial background as white or Caucasian, 19% Aboriginal or First Nations, 9% Black or African/Caribbean Canadian, 5% Asian and 2% Hispanic or Latin American. Some of the participants of the focus groups and arts-informed component had also participated in the survey. The focus groups had higher ratios of women and people of color participating, than was present in the survey population.

⁴ Methamphetamine

⁵ Injection drug use

⁶ 24 years of age in the past 6 months

Survey/Interview Sites

Participants were recruited at various youth-serving agencies across Toronto. Our survey sites were located from Sheppard Avenue in the north to King Street in the south and from Sherbourne Street in the East to Caledonia in the west. In total, seven different recruitment sites were utilized. Two were community health centres (34 participants), three were youth shelters (28 participants) and 2 were youth drop-in centres (38 participants). Recruitment sites were chosen based on their provision of services to youth who met the survey's eligibility criteria as well as representing the diversity within homeless youth populations (i.e. gender identity, sexuality, ethno racial background); were located in different geographical areas of Toronto (i.e. downtown and non-downtown); ability to provide a welcoming and non-judgmental environment for youth who use substances; and their ability to provide appropriate supports in regards to being a recruitment site (i.e. confidential space and staff support to the research team and to participants).

Focus Group Sites

Four of the focus groups were conducted at Shout Clinic and one was conducted at a public library which was routinely used to do community programming by a host agency. In addition, the focus groups were advertised at all of the recruitment sites as well as other youth-serving agencies.

Arts-Informed Component Site

Sketch was chosen as the site to recruit and conduct all activities involved in the arts-informed component. The focus of their work is to provide creative opportunities for street involved and homeless people ages 15-29, engaging them in the arts in a cross-discipline studio environment.

Recruitment

Shout Clinic invited youth-serving community agencies in which Shout had a connection to become partners in this study. Some of the partnerships were for the purpose of establishing host agency sites in which to recruit youth and to conduct the

survey/interviews, focus groups and the arts-informed component activities. Other partnerships were established to promote the study to assist in the recruitment process and to consult in regards to the study tools.

Host agencies were provided with the funding proposal, survey instrument, study information sheet, promotional flyer, participant consent form, eligibility screening form and protocols for recruiting study participants. Based on the eligibility criteria, staff at the partner host agencies recruited and scheduled youth for the study. The staff at each participating host agency explained the study to potential participants and that participation was voluntary. As part of the recruitment process, staff of the host agency screened each participant using the eligibility screening form. Staff provided participants with interview/focus group appointment times and dates. In addition, to ensure that participants truly met the study criteria, they were re-screened by the peer researchers and/or the principal investigator prior to their participation. All participants of the study signed a consent form. As part of acquiring informed consent, participants were given a copy of the consent form which was read to them prior to signing it.

The Survey Instrument

Our survey instrument was pilot tested with youth who met the study's eligibility criteria and the peer researchers. Survey questions drew upon a variety of resources, including surveys conducted by other community agencies/researchers and questions created specifically for the purpose of this study. The survey instrument consisted of 78 questions, most of which were pre-coded to allow for quantitative analysis. All of the questions gave participants the option to answer with "refused" or "don't know". Some of the questions consisted of multiple parts and/or skip pattern style questions. Many of the questions had an "other" option which allowed participants to include additional information. As well, there were some open-end questions to allow for qualitative analysis. Survey interviewers used visual cards to ask questions relating to the

frequency of an activity (i.e. never, occasionally, sometimes, usually, and always) and those which asked respondents to rate the importance (i.e. high, low and no importance) of a harm reduction service, resource or an approach to service delivery. These cards were utilized to assist in creating a standardized and consistent form of measurement in regards to respondents' answers. Questions in the injection drug use, crack use and methamphetamine sections of the survey were only asked to participants who said yes to these activities when they were screened by the interviewer. The survey instrument consisted of 9 sections: Demographics and ethnicity, housing and homelessness, substance use, injection drug use, crack use, methamphetamine use, harm reduction services, health and social issues, sex practices, and participants' and interviewers' comments. A copy of the survey is available upon request.

The Focus Group Instrument

A discussion guide was developed for the focus groups which consisted of twenty open-ended questions. The focus group questions reflected the same themes as the survey instrument and allowed examination and reflection on the survey results; as well as facilitating recommendations and ideas for new initiatives from participants. A copy of the discussion guide is available upon request.

The Arts-Informed Component Activities

The purpose of this component of the needs assessment was to give youth another type of voice (through art making) in regards to the issues faced by, and the needs of, homeless and street involved youth who use substances. Participating youth created artwork which reflects the themes of this research (homelessness and housing, drug use and practices, health and social issues). Their artwork is showcased in this report. Participants attended an orientation session and accessed studio time to develop and complete their art projects. In addition, a youth team leader was recruited to lead the orientation session and to provide support and mentoring to the participants. The principal investigator provided participants with an overview

of the research project goals, harm reduction principles and characteristics of participatory community-based and arts-informed research. These included examples of art from other research projects. In addition, Sketch's Youth Team Leader and the Youth Worker developed and led participants through an art warm-up exercise and an art brainstorm to assist them in the development of their individual project work plans.

Data Collection

A multi-method design was used to produce the research data. The survey/interviews were carried out from October 2008 to December 2008 and the focus groups were conducted from April 2009 to June 2009. Hence this study presents a recent picture of the health status of a segment of the homeless population that is heavily involved in substance use and related risks. Survey/interviews and focus groups were conducted during times of the day in which participants were most apt to be accessing services at the partnering host agency. Most of the interviews were conducted in the afternoon and in the evening; at other times they were conducted first thing in the morning or late at night (i.e. after midnight). The survey was done in an interview format to include any participants with literacy and vision problems. All of the interviews were conducted by the peer researchers (with the exception of ten which were conducted by the principal investigator). Survey interviews were conducted verbally and one-on-one with interviewers reading the surveys and recording respondents answers. The focus group discussions were audio taped and recorded by a note taker. On average, the surveys and the focus groups took 45 minutes to 75 minutes to complete. Survey participants received a \$15 honorarium and two TTC tokens, and the focus group participants received a \$15 honorarium, two TTC tokens and a \$10 Subway Sub gift certificate for their time.

Data Analysis

After data collection (from the surveys) was completed, each survey was given a sequential identification number to assure confidentiality. The

next step involved manually entering the coded data into a database (SPSS). Once the data from the surveys were entered, data were subsequently "cleaned" to ensure that data codes were consistent with the raw data collected which produced an SPSS dataset for analysis. Frequency distributions of all variables were produced, along with descriptive statistics, cross-tabulations and bivariate analyses (chi-square). Participants' responses to open-ended questions were reviewed and when appropriate they were incorporated into this report and in some cases used as direct quotes. Focus group data were analyzed by identifying recurring themes from the discussions. As well, some quotes were used to illustrate key ideas, issues, themes and recommendations.

Community Involvement

Two youth peer researchers with lived experience of homelessness and substance use were hired and received training appropriate to their skill level and the demands of the job (i.e. participatory community-based research and how to administer the survey and conduct interviews and focus groups). The peer researchers hired had extensive experience working in the harm reduction field. As well, they had worked with the principal investigator on previous harm reduction projects in which they received training that was relevant to this research project. The peer researchers administered the survey interviews, co-facilitated the focus groups, provided invaluable input into the design of the study tools (i.e. the survey and the focus group discussion guide) and assisted with data analysis. Peer researchers were paid an hourly wage of \$15 for all aspects of their work (meetings, trainings, conducting the survey and focus groups) and were compensated for any travel that was required. In addition to hiring peer researchers, this project also piloted the research tools with youth who met the study's eligibility criteria; their feedback allowed us to make positive changes to the research tools and the interview format.

Street youth are a marginalized population that is notoriously difficult to access and to engage in an in-

depth, personal interview about their lives. A key ingredient to the success and strength of this study was that it employed a peer researcher model. We believe that one of the most important benefits to using this model is that it creates the conditions necessary for marginalized youth who use substances to feel comfortable enough to open up about their experiences without fear of being judged. In addition, by incorporating the opinions of peer researchers and research participants into the development and implementation of the research tools and the data analysis, it provided a sounding board based on lived experiences. This facilitated a richer understanding of the data collected and grounded the recommendations. In addition, it created an opportunity for the peer researchers to develop transferable and employable skills. One of the other benefits of involving community members in different aspects of this project was that it provided participants with a sense of ownership and self-worth and gave a clear message that their opinions and experiences were of value.

Ethical Issues

In advance of carrying out the study activities, we identified a number of ethical issues that were likely to occur during the course of the study. We anticipated that participants who were attempting to not use either as part of a 'drug holiday' or as a long term goal may experience a trigger which would result in them feeling uncomfortable, upset and/or wanting to use substances. As part of piloting of the study instruments (e.g. survey), we discussed this issue with potential participants (some of whom were not using at the time) and with peer researchers. Youth felt that it was very important that they not be excluded from participating in the study. In order to be proactive in addressing this issue, host agencies were given very clear guidelines in regards to discussing with potential recruits possible harms they may experience as a result of participating in the study, including triggers. In addition, as part of acquiring signed consent, peer researchers discussed with participants potential harms, their right to ask for a break and/or end their participation in the study, and the role of the host

agency in providing support to them if needed. As well, peer researchers were trained to identify and support participants who were experiencing a trigger and/or seemed in discomfort or distress.

Another foreseen ethical issue was whether or not to address situations in which it was clear to the peer researchers that participants were engaging in risky and harmful behaviours as a result of misinformation (for example, not knowing that sharing water and cookers with other injectors is a risk for Hepatitis C). At the end of the interview, Peers were given latitude to inform participants of the risks and to encourage them to speak with staff of the host agency in order to discuss their concerns and to receive education and support. At the end of each interview and focus group, participants were offered brochures for Shout Clinic and needle exchange programs. In addition, the principal investigator was always on site in case peer researchers needed to consult with them. As well, debriefing sessions were conducted with peer researchers after each interview, at the end of the day, and after each focus group.

Study Limitations

Our findings are not necessarily representative of all homeless youth who use various substances as this was not the focus of the study; our target group was specifically the extremely vulnerable and absolutely homeless youth who use specific substances and risky methods of use. As well, this data may not be representative of substance use patterns, preferences and availability found in other Canadian cities.

Our study attempted to recruit youth from different geographical areas of Toronto (i.e. downtown and non-downtown areas). Due to the lack of harm reduction programs servicing homeless and street-involved youth who met our criteria there were certain areas of Toronto in which we were not able to recruit host agencies and/or youth.

All activities of this study were conducted in English (e.g. survey interviews and focus groups). By

excluding individuals who were not comfortable participating in English, our sampling may not reflect the racial and ethno-cultural diversity which exist within the homeless youth population.

In order to ensure that we were able to recruit youth who met our eligibility criteria, the survey interviews were conducted at various youth serving agencies across Toronto. A limitation of the study was that by participating, youth would need to disclose their substance use to staff of the host agency. In order to mitigate confidentiality concerns, we purposely formed partnerships with community-based agencies that provided harm reduction programs to homeless and street-involved youth and where participants had established trusting relationships with staff.

Due to substance use being the central focus of this study, issues relating to sexual health were a peripheral topic of investigation.

Dissemination

Our findings will be disseminated via conferences, forums and other educational events, committee and coalition meetings, health/community fairs, web sites, publications, direct mail and other mediums for dissemination.

ABOUT SURVEY RESPONDENTS

In total, we interviewed 100 youth. The figures throughout this section refer to the total sample.

GENDER IDENTITY

- 75% identified as male
- 21% identified as female
- 4% identified as transgender or transsexual

AGE

Respondents ranged from 16 to 25 years (was 24 years of age within the past six months). The average age of survey participants was 21 years.

Age distribution

Age Groups	%
16 – 18 years old	15%
19 – 21 years old	39%
22 – 24 years old	42%
25 years old (was 24 years of age within last 6 months)	4%
	100%

SEXUAL ORIENTATION

Research has shown that youth who identify as lesbian, gay, bisexual, transgender or transsexual are at an increased risk for some health and social issues, and due to discrimination issues they face barriers and challenges in accessing services and supports.

- 61% of our sample identified as heterosexual
- 31% identified as lesbian, gay, bisexual, two-spirited, transgender or transsexual
- 3% did not know
- 1% identified as asexual
- 4% refused to answer the question

ETHNO-RACIAL BACKGROUND

Respondents were asked to identify their primary ethno-racial background.

Ethno-racial Background

Groups	%
White or Caucasian	63%
Aboriginal or First Nations	19%
Black or African/Caribbean-Canadian	9%
Hispanic or Latin American	2%
Asian	5%
Don't know	2%
	100%

PLACE OF BIRTH

90% of respondents were born in Canada. Of the 10% who were born outside of Canada 5% came from Europe (3% from Eastern Europe, 1% Germany and 1% Ireland), and 3% came from America, 1% Jamaica and 1% Brazil.

92% of all respondents had Canadian citizenship, 3% had dual citizenship, 3% were landed immigrants, 1% had an education or visitor visa, 1% had American citizenship.

Of those who were born outside of Canada, the average length of time respondents had lived in Canada was 13.5 years. The minimum was 1 year and the maximum was 24 years.

A majority of the youth we interviewed had lived in Toronto for 3 or more years (69%), 18% had lived in Toronto for 1 to less than 3 years, 6% had lived in Toronto for 6 month to less than a year, 7% had lived in Toronto for less than 6 months.

EDUCATION

The majority of the respondents did not complete high school and only a small minority completed college or university. Of those who did not complete high school (n=61), 2% completed grade twelve, 37% completed grade eleven, 27% completed grade ten, 32% completed grade nine and 2% completed grade eight. Out of the one hundred respondents, there were twelve currently enrolled in school, six full-time and six part-time.

Education

Highest Level of Education Completed	%
Grade 5 – 8 (Elementary only)	18%
Some High School (no diploma)	61%
High School	12%
G.E.D. or Other High School Equivalency Certificate	3%
Some College or University	2%
Completed College or University	3%
Unknown	1%
	100%

SOURCES OF INCOME

Securing stable and safe sources of income, such as legal employment and government assistance is an important resource which has the potential to enhance youth’s ability to secure and maintain housing, increase self-esteem and decrease social isolation. At the time of the survey, only 10% of youth we surveyed had their own place of residence and were paying rent.

It is clear that the youth we surveyed engaged in a variety of activities to earn money, many of which are unstable and come with certain risks. Survey respondents’ monthly income was made up of a patchwork of sources. The impact of this was that

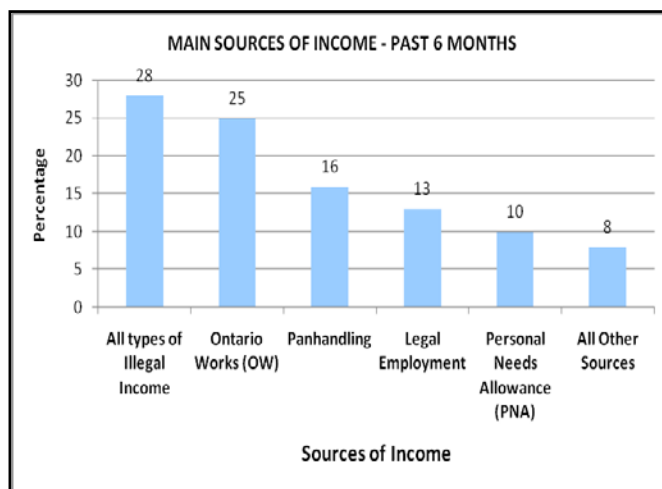
youth found it extremely stressful and difficult to balance the multiple economic demands they faced, such as rent, food and paying for drugs.

“There’s never enough money when you have a habit that becomes an addiction.”

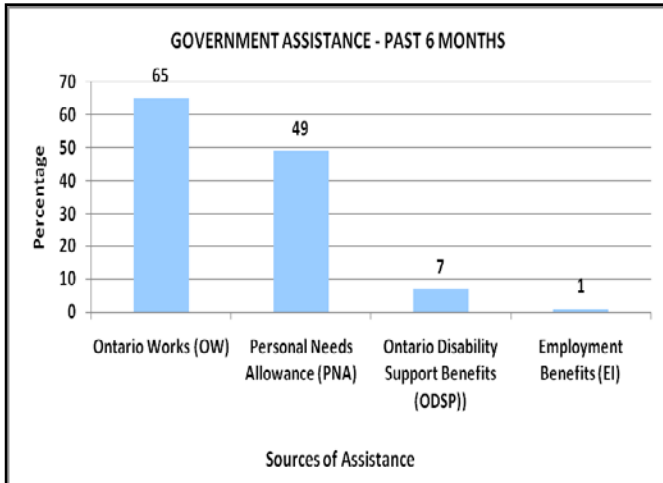
Focus group participants spoke of feelings of shame and frustration due to being unemployed. For some, unemployment led to increased substance use.

“If you are homeless, you’re likely to be jobless and therefore you have more time to do and experiment with more drugs.”

The following chart represents the main sources of income that youth relied upon in the past six months, with illegal activities being the primary source (28%). Only 13% of youth indicated that legal employment was their main source of income and 25% reported Ontario Works as their main source.



The following charts show survey respondents’ various income sources for the past six months. They are broken down into four groups: legal employment, government assistance, illegal income and other sources of income. Multiple responses were permitted.



Youth staying in shelters received a personal needs allowance (PNA) benefit, which is a stipend that shelters give to their residents to cover incidental needs not covered by the shelter. PNA is \$3.90 a day and \$109 to \$120 per month.

A large portion of youth (65%) had received Ontario Works (OW). The basic rate for a single person on OW is approximately \$548 per month.

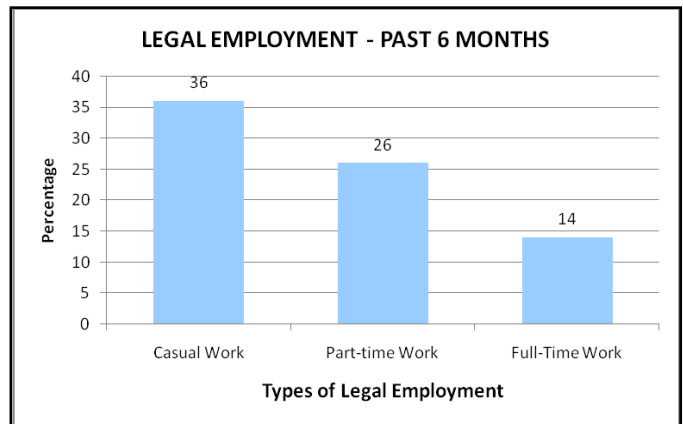
Despite the fact that many of the youth we surveyed reported having a potentially disabling health condition, (37% have been diagnosed with a mental health problem) only 7% had received Ontario Disability Support Program (ODSP) benefits. The ODSP rate is \$979 per month⁷. Health issues such as mental health conditions and/or developmental and learning disabilities add to the many difficulties youth face when applying for ODSP benefits. 33% of our respondents reported being diagnosed with attention deficit disorder (ADD), another 20% with a learning disability other than ADD.

Focus group participants reported experiencing stigma related to their receipt of social assistance. Some found that they were not able to get housing if

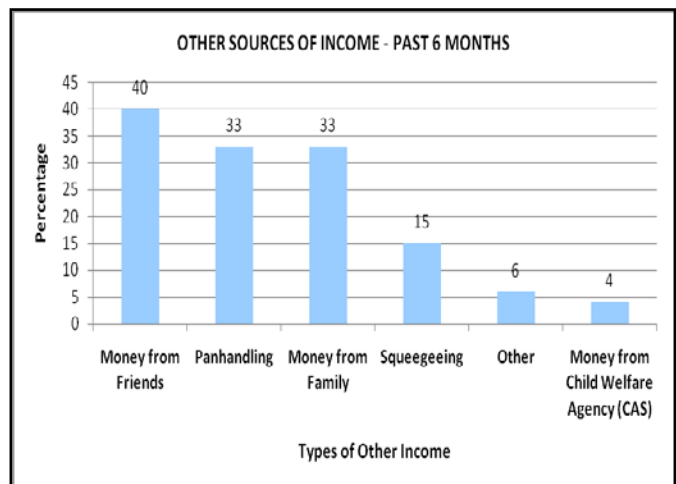
⁷ The ODSP application process is a complex system to navigate and complete successfully. Applications are often denied, forcing the applicant to either give up or to go through an appeals process.

the landlords knew they were receiving OW or ODSP.

“Landlords discriminate against me because I’ve been on government funding or ODSP. They may not necessarily allow you or offer you the chance because you’re on a fixed income.”

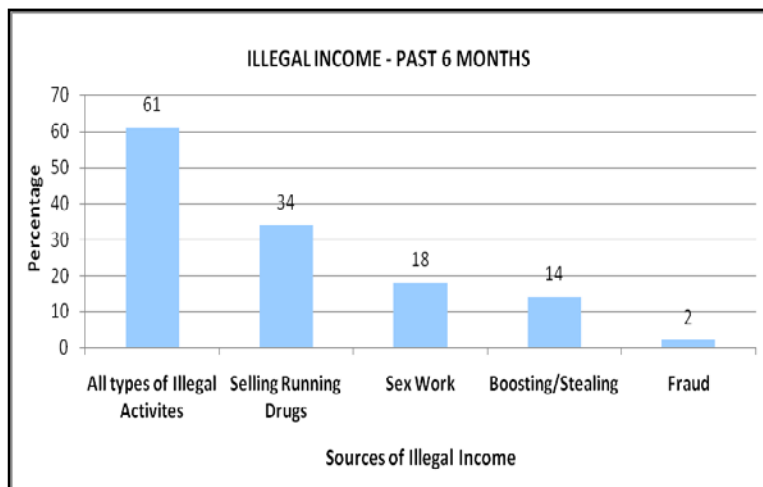


Some youth had legal forms of employment, with casual work being the main source (36%). 33% of respondents reported using drugs to cope with their legal job. Focus group participants reported that looking for work was very difficult and stressful for youth, even with the assistance of an employment counsellor.



Youth also relied on informal sources of income, including panhandling and squeegeeing. Money

from friends and family generated small and infrequent source of income for youth.



A large portion of youth engaged in illegal activities for a source of income, such as sex work, stealing/boosting and drug dealing/running.

41% of survey respondents reported using drugs to cope with illegal work activities. Some male focus group participants spoke of feeling shame and stigma due to involvement in sex work.

“The sex industry makes you want to do drugs to begin with. You make the money and you think, let’s do drugs. Let’s forget that horrible thing I just did.”

Due to the social stigma and illegal nature of these forms of income, some youth may have been reluctant to disclose their involvement in these activities even to peer researchers. Thus the numbers of youth involved may be larger than reported in this survey.

HOMELESSNESS AND HOUSING



The Maze by Gaara

AGE OF FIRST EXPERIENCE OF HOMELESSNESS

Many of the youth surveyed had been homeless since an early age, many for periods longer than a year. 44% of youth surveyed had experienced homelessness prior to turning 16 years of age. The following table show the participants ages and when

they first experienced homelessness. 7% first became homeless when they were 12 years or younger, 37% between the ages of 13 to 15 years, 42% between the ages of 16 to 18 years age and 14% between the ages of 19 to 22 years.

Current Age	Age of 1st experience of homelessness (n=100)				Total (n=100)
	12 years & under	13 to 15 years	16 to 18 years	19 to 22 years	
16 - 18 years old	0% (n=0)	11% (n=4)	26% (n=11)	0% (n=0)	15%
19 - 21 years old	57% (n=4)	46% (n=17)	36% (n=15)	21% (n=3)	39%
22 - 24 years old	29% (n=2)	38% (n=14)	36% (n=15)	79% (n=11)	42%
25 years old (24 yrs of age within last 6 months)	1% (n=1)	5% (n=2)	2% (n=1)	0% (n=0)	4%
Total (%)	7%	37%	42%	14%	100%

SOURCES OF SHELTER

Homeless youth experience numerous barriers in regards to acquiring and maintaining stable safe shelter and housing. Like their sources of income, the youth we surveyed relied on a wide range of sources of shelter, many of which are unstable, unsafe and expose youth to potential risks. Locating shelter is a daily task for homeless street-involved youth. Many focus group participants described being homeless as very depressing and stressful. Using drugs was cited as a common strategy for dealing with living on the streets and in shelters (65% of survey respondents reported using drugs to cope with homelessness).

“It’s so depressing being homeless I just wanted to get high. It didn’t matter on what.”

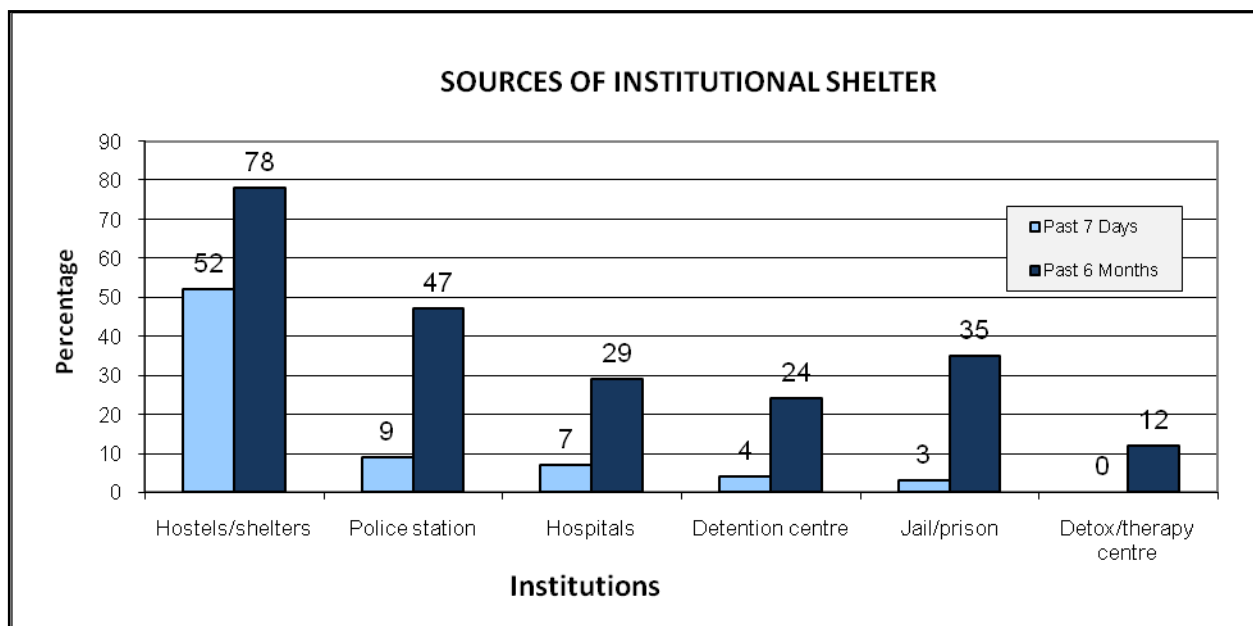
The following charts show youth’s many sources of shelter for the past seven days and the past six months (i.e. places they stayed at for at least one whole night). They are broken down into five groups: institutional indoor shelter, and two types of non-institutional indoor shelter, independent and relationships (people participants stayed with), transient indoor shelter (businesses), and outdoor shelter. Multiple responses were permitted.

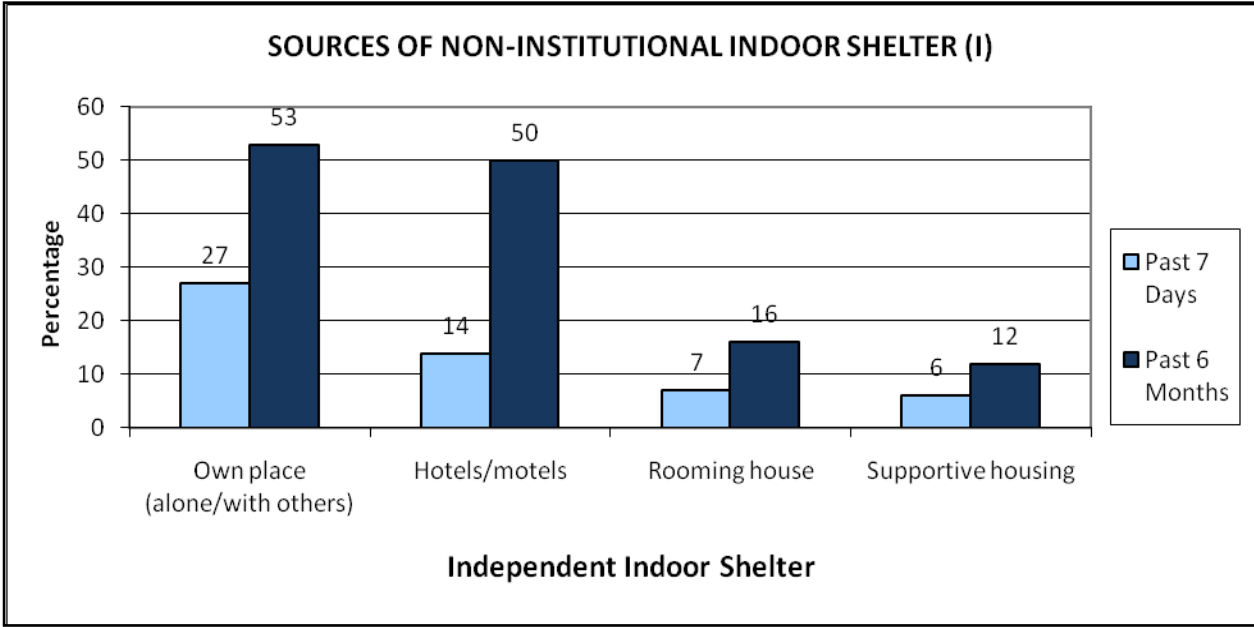
The five most common sources of shelter that survey respondents had used were:

- Hostels/shelters (78% past six months, 52% past seven days)
- Staying with a girl/boy friend, friend or acquaintance’s place (69% past six months, 40% past seven days)
- A place that they rented either alone or with others (53% past six months, 27% past seven days)
- Sleeping on the street and in alley ways (52% past six months, 19% past seven days)
- Hotels/motels (50% past six months, 14% past seven days)

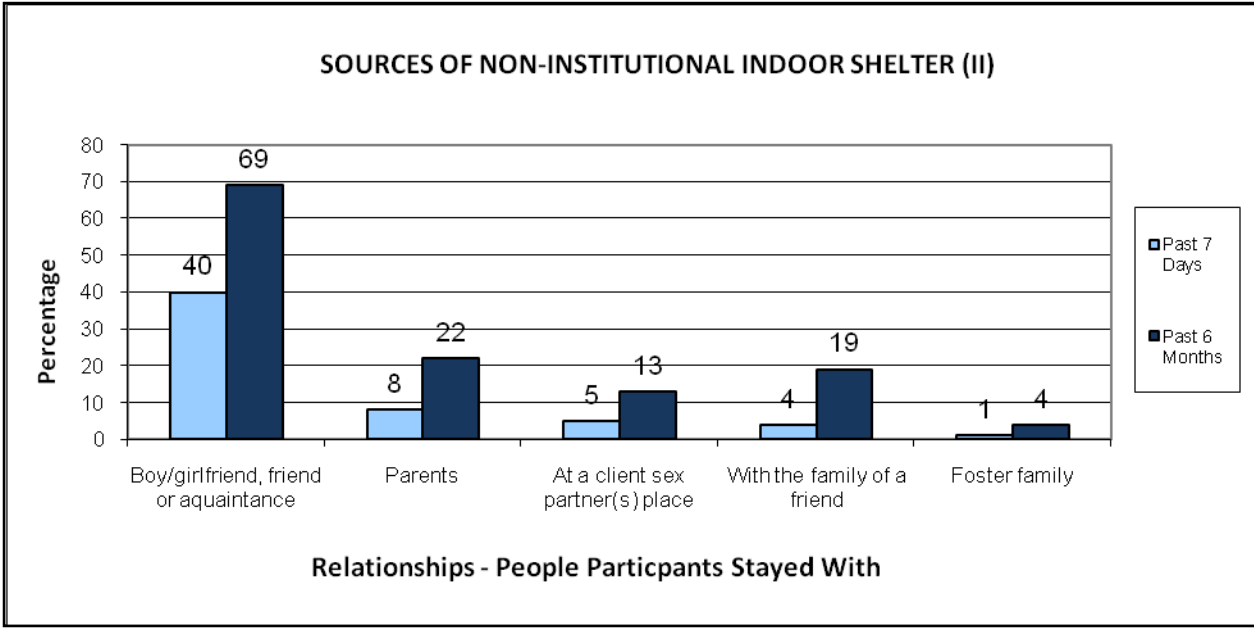
In addition, jails/prisons (35%), police stations (47%), parks (46%), stairwells (43%) and abandoned buildings/squats (35%) ranked high for sources of shelter in the past six months.

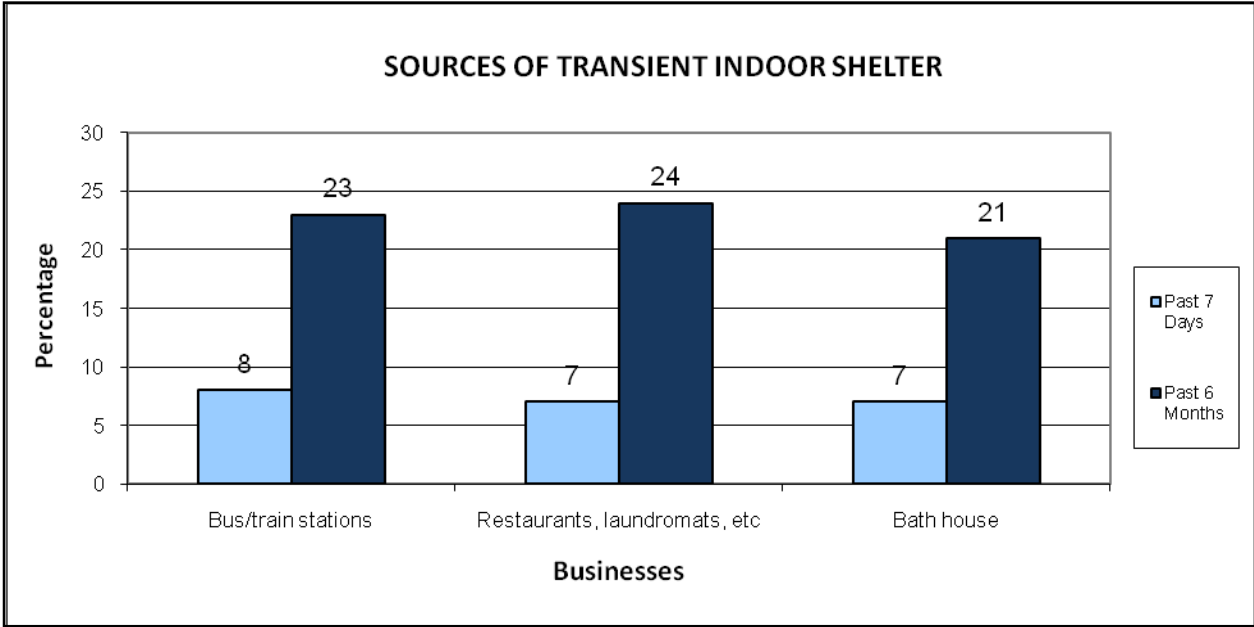
“Just being in a shelter can make you want to escape.”



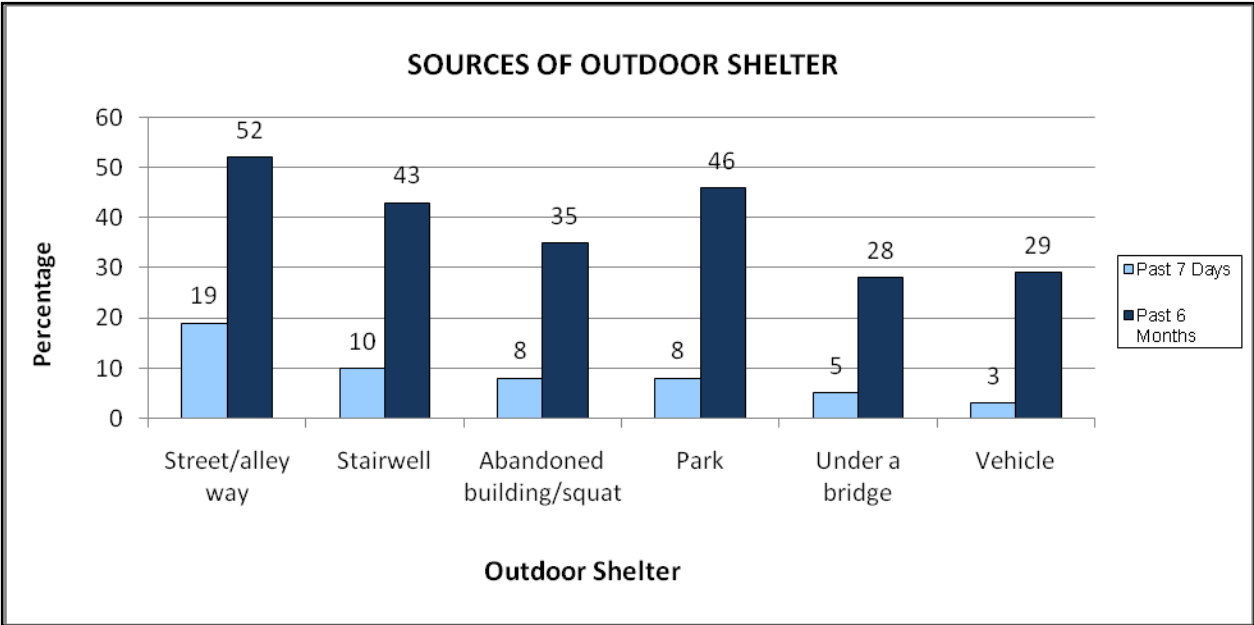


“Ya, you don’t have the money to pay for a place and the places welfare will pay for are like a hole in the wall. You get like \$356 for rent. That’s enough to get a tiny room.”





“I would do ecstasy so I could stay up all night or be warm and functional, not be rolled up in a ball in the middle of winter. At least I’d be walking around, have energy, be with friends.”



HOMELESS AND HOUSING ISSUES

Exposure and Access to Drugs

Perspectives varied amongst focus group participants in the ways exposure and access to different types of substances was related to their housing status. Many felt that they became more exposed to different types of substances while on the streets or in shelters and that exposure (and therefore access) would continue once housed. This may be in part, related to the social networks developed while on the street and in shelters.

“Being homeless, it’s a lot easier to get certain drugs. Word-of-mouth, you hear lots of things. It’s a lot easier but it’s not good.”

Safety Issues

Overall, feelings of safety were related to where they were currently living or staying. Of the 10% of survey respondents who had their own place and were paying rent at the time of participating in the survey, 40% said they felt completely safe and 50% felt quite safe and 10% felt somewhat unsafe. Of those who did not have their own place when interviewed, only 28% felt completely safe, 39% felt quite safe, 22% felt somewhat unsafe, 5% felt quite unsafe and 6 % felt completely unsafe.

When asked about safety, focus group participants shared fears of being stabbed, physically or sexually assaulted, robbed, and verbally abused. Exposure to the elements, police harassment and arrest were also cited as risks youth faced.

“You aren’t somewhere safe, they can grab you.”

While staying in shelters might provide a sense of security in some ways (i.e. from the elements, from arrest), youth still face a great deal of instability and stress in the shelter system. Focus group participants were fearful of being discharged from certain shelters if they admitted using drugs. Many reported being discharged while under the influence and that they would avoid these shelters when using substances.

Becoming housed didn’t always solve the problem of safety and stability for youth. Some participants found that the stress and trauma they experienced prior to as well as while homeless led back to drug use and sometimes led to losing their housing.

“I think it’s hard to keep housing just because you want to relax, get away from the homelessness, but you still have to deal with some of the stuff that happened to you while you were homeless.”

Finding and Maintaining Housing

Focus group participants consistently spoke about the difficulties they experience and the negative impact that poverty, homelessness, discrimination, substance use and instability has on their ability to find and maintain affordable housing.

“I can’t make it to appointments because I’m sleeping in because I was up late the night before. So, I have a housing appointment and I don’t make it.”

Discrimination due to their age, lack of previous rental experience, substance use, homelessness and unemployment is a major obstacle that youth face when searching for housing.

“I went to see a place and he noticed my arms...the scars...tracks or whatever. Just by looking he knew I was a user and I didn’t get the apartment. He didn’t want to show it to me anymore.”

Participants also spoke of the quality of housing options as being limited due to the high cost of living and the lack of affordable housing. Youth expressed frustration that often the only available housing was located in low-income neighbourhoods and buildings that are primarily inhabited by individuals with mental health and substance use issues.

“All the low income housing is in bad areas. So like you’re trying to get away from all of that and the only place you can live is right in the middle.”

A common theme within the focus groups was the challenge of maintaining housing while surviving on social assistance and struggling with substance use issues, even with rent supplements. Some focus group participants felt that harm reduction strategies helped mitigate the negative economic impact of substance use.

“Even if you do maintain housing, you maintain it for a period of time, and then you become a little bit more addicted than you were before you maintained the housing, then your rent money is geared towards your drug or your addiction and then you start selling things in your home.”

Participants debated whether or not being housed influenced their frequency of drug use. Some felt that being housed might lead to longer binges and more frequent use due to not needing to take a break to find food or shelter; and a lack of concern regarding being seen by the public or police. Others felt that their substance use was deeply connected to coping with the stress of life on the street and in shelters. Some felt that choices regarding drug consumption were influenced by addiction issues not housing status. Participants also spoke about binging as a major risk factor for losing one’s housing.

“One bad night, that’s all it takes, is one bad night.”

In addition, imprisonment and hospitalization were also noted as situations which jeopardized one’s ability to maintain housing as social assistance benefits may be suspended while one is in an institution. 51% of survey respondents had been imprisoned in the past year, 33% of them for periods longer than a week. Suspicion or proof of criminal activity can also be a reason for eviction (i.e. drug dealing on the premises).

Housing and Stability

More significantly, a number of the youth stressed that without having to worry about where they will sleep or get food, they could turn their focus to other things like enrolling in programs, looking for employment, engaging in self-care activities and receiving drug treatment. They clearly stated that stability and appropriate housing is a foundation for moving forward and making positive changes.

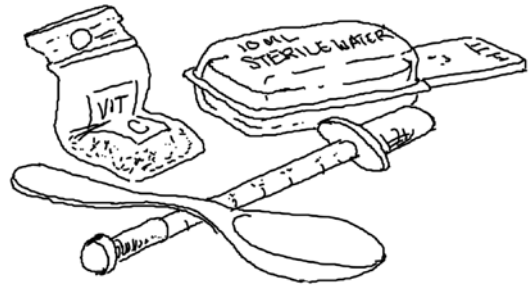
“If I have some place to come home to all the time, then I focus on the next step.”

SUBSTANCE USE

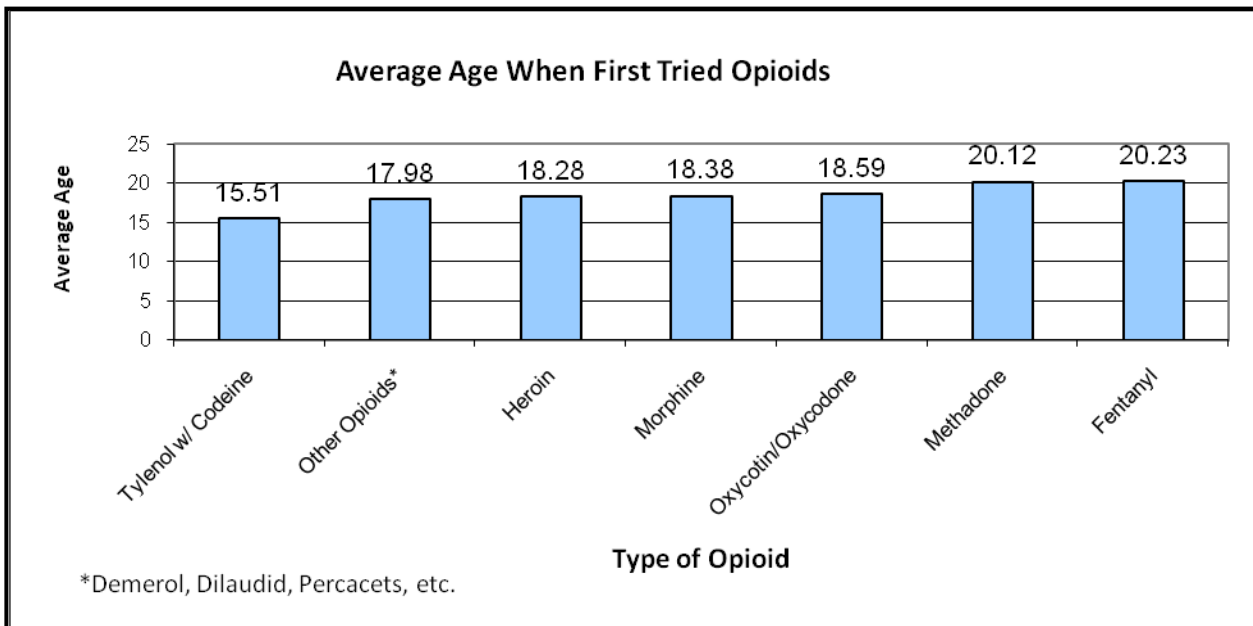
AGE OF FIRST USE

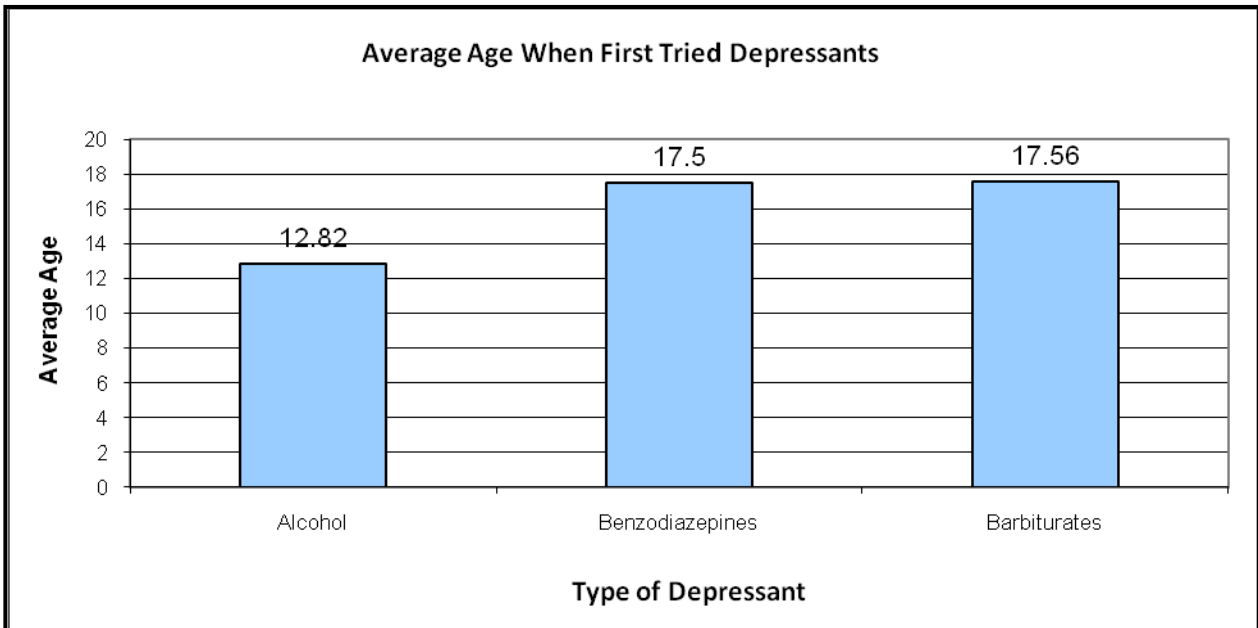
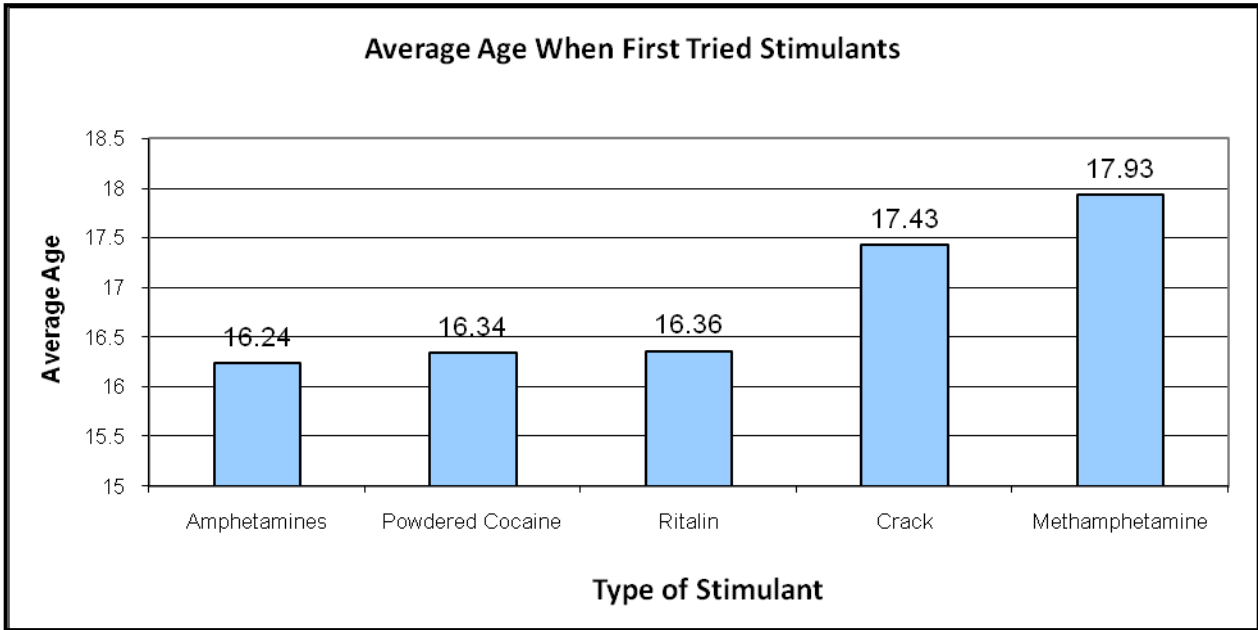
Initiation ages for first use of drugs are often influenced by factors such as:

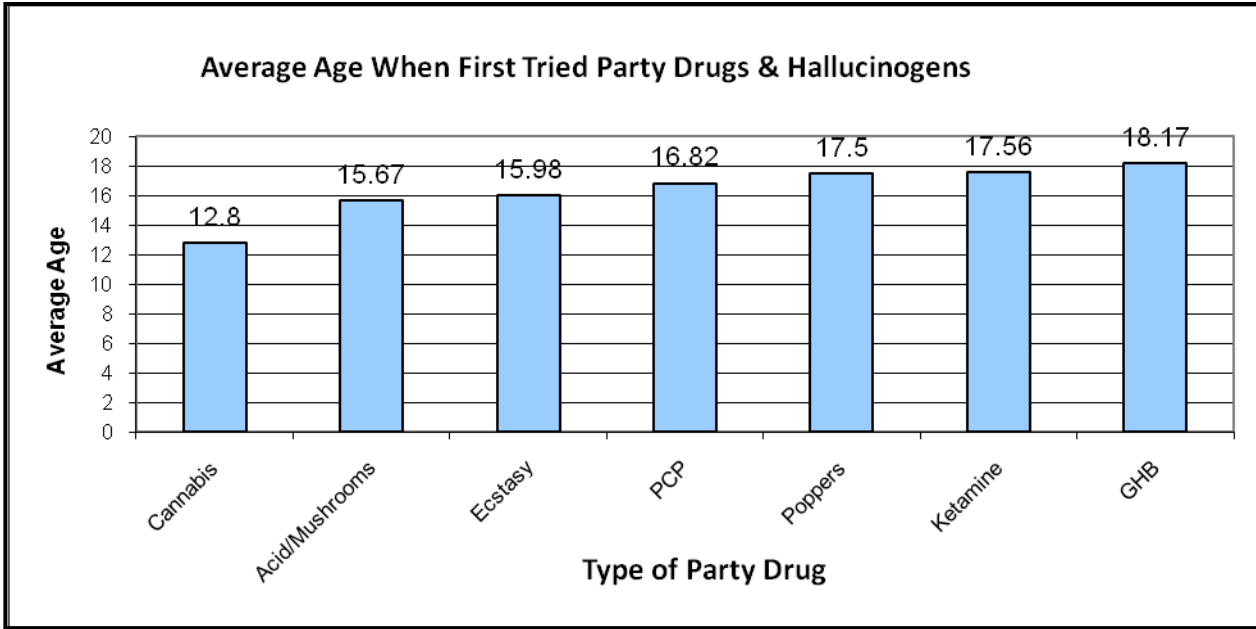
- Drug availability: drug market, access to drugs and/or dealers
- Drug use trends: popularity of a drug at specific time period
- Environment: where youth are living/hanging out
- Social networks: who youth are living/hanging out with
- Motivation of individual: what is the reason they are using substances



The average age in which survey respondents reported first use of cannabis and alcohol was around age 12, then acid, mushrooms, ecstasy and Tylenol with codeine in the age 15 range, followed by cocaine, Ritalin and PCP by age 16. Crack, methamphetamine and heroin came later, at average ages of 17 – 18 years. The following charts illustrate survey respondents' average age of first use (ages nine years and up).







For many of the survey respondents, age of first use was *much younger* than the overall *average ages* and in many cases it was younger than age 16. This is important as youth are generally accessing harm reduction services through youth serving agencies who serve youth ages 16 and older. Age restrictions act as barriers to minors’ access to harm reduction supports, materials and education, which increases their risk for drug related harms, such as disease transmission; and increases their vulnerability to being exploited by peers and older people.

Opioids - age of first use:

- 15 respondents had used Oxycotin/Oxycodone between the ages of 12 – 15 (average age was 18.59)
- 14 respondents had used Tylenol with codeine between the ages of 12 -14 (average age was 15.51)
- 10 respondents had used other opioids between the ages of 13 – 15 (average age was 17.98)

In Stimulants – age of first use:

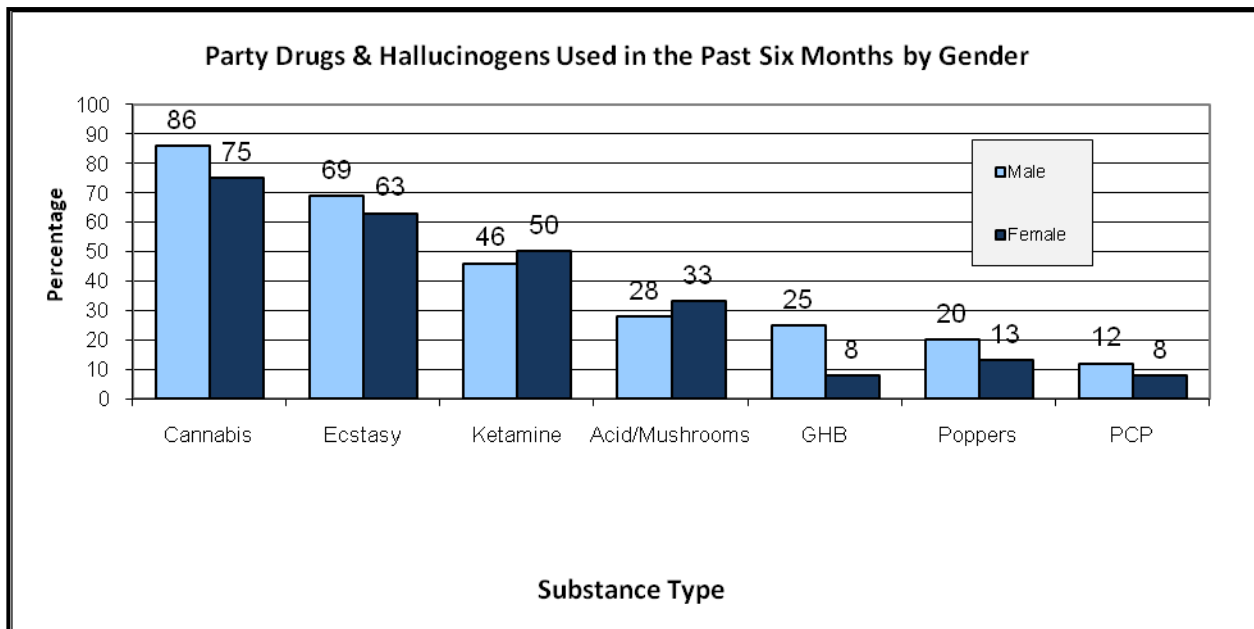
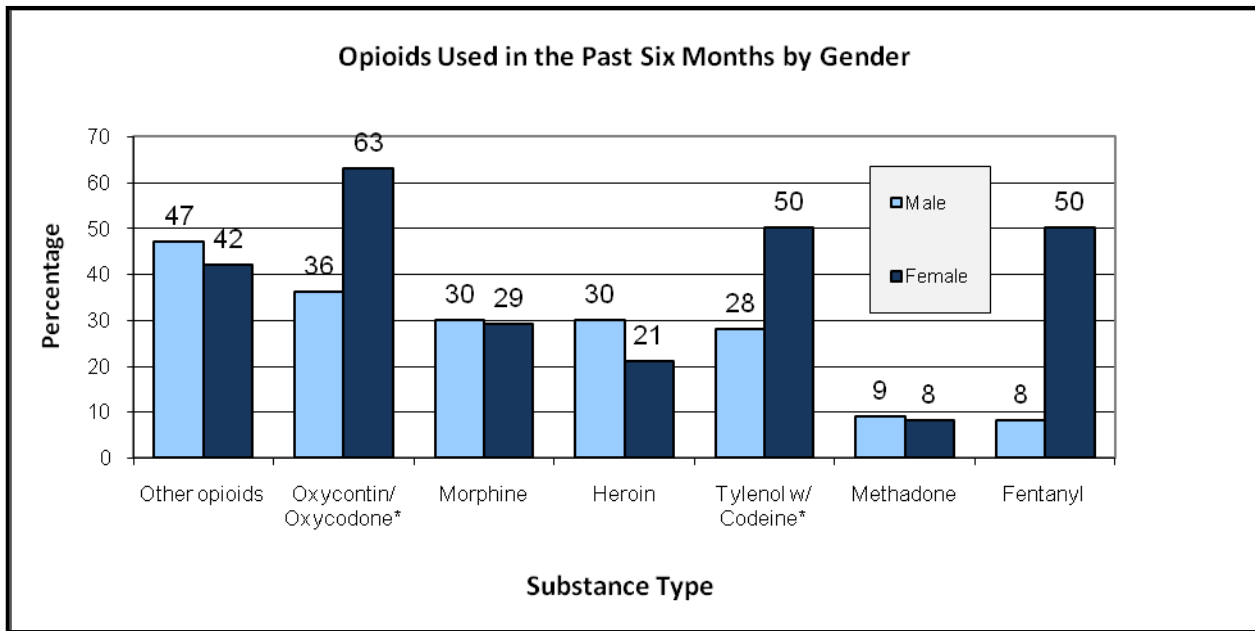
- 32 respondents had used powdered cocaine between the ages of 10 – 15 (average age was 16.34)
- 15 respondents had used amphetamine between the ages of 11 – 15 (average age was 16.24)
- 13 respondents had used methamphetamine between the ages of 13 – 15 (average age was 17.93)
- 15 respondents had used crack between the ages of 12 – 15 (average age was 17.43)

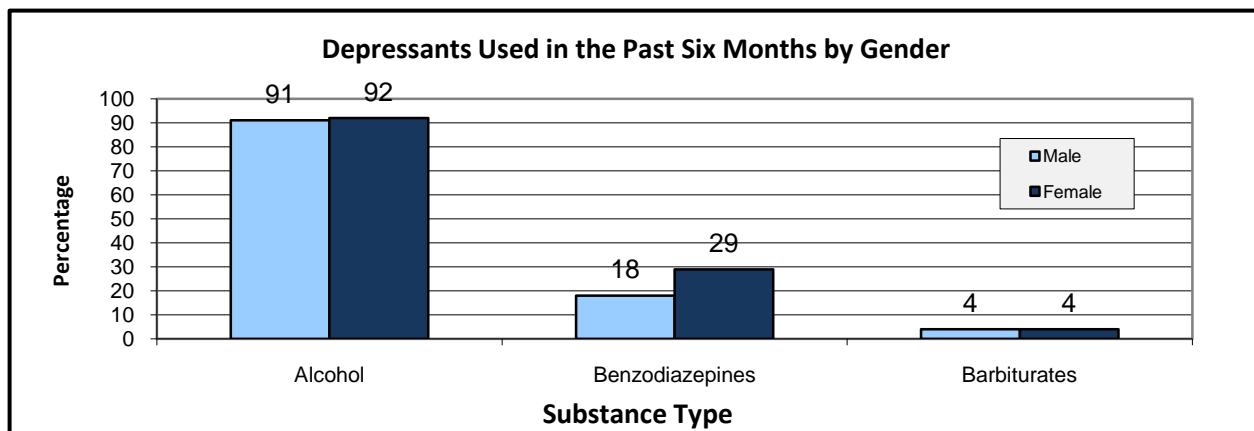
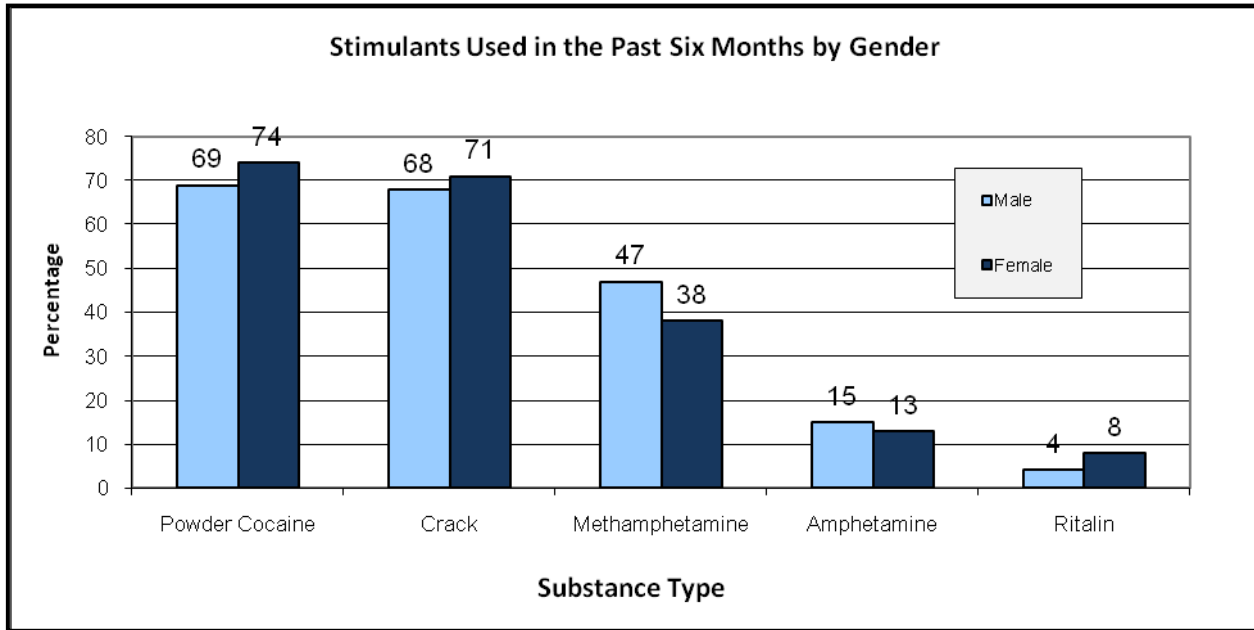
Party drugs and hallucinogens – age of first use:

- 26 respondents had used acid/mushrooms between the ages of 11 – 14 (average age was 15.67)
- 25 respondents had used ecstasy between the ages of 11 – 14 (average age was 15.98)
- 15 respondents had used Ketamine between the ages of 12 – 15 (average age was 17.58)

SUBSTANCE USE HISTORY – PAST SIX MONTHS

The following charts illustrate survey respondents' substance use history for the past six months by gender. In general there were no significant differences in regards to gender with the exception of opioid use. There were significant differences between male and female use of Oxycontin/Oxycodone, Tylenol with Codeine and Fentanyl (Pearson <0.05 for chi square test).





Of the 71 survey respondents who had used crack in the past six months:

- 9% used crack several times every day (more than 5 times a day)
- 16% used once daily
- 25% used regularly (3 to 4 times per week)
- 17% used less regularly (once to twice a week)
- 29% of youth used infrequently (1 or 2 times per month)
- 4% did not know how often they used crack

Of the 51 survey respondents who had used methamphetamine in the past six months:

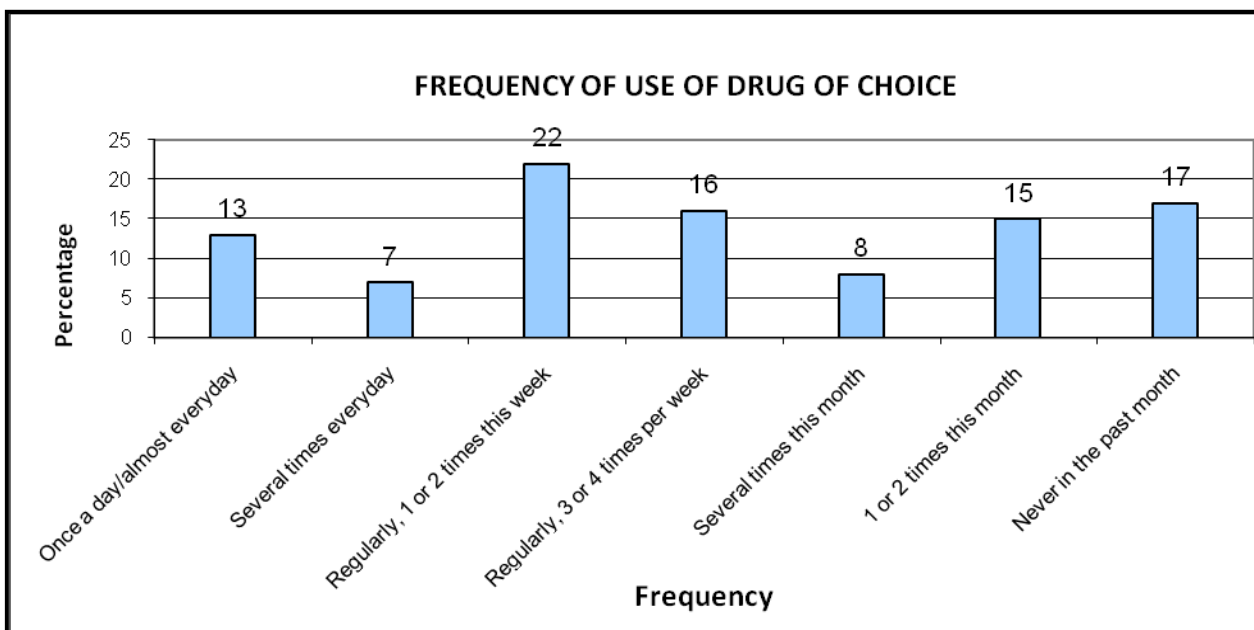
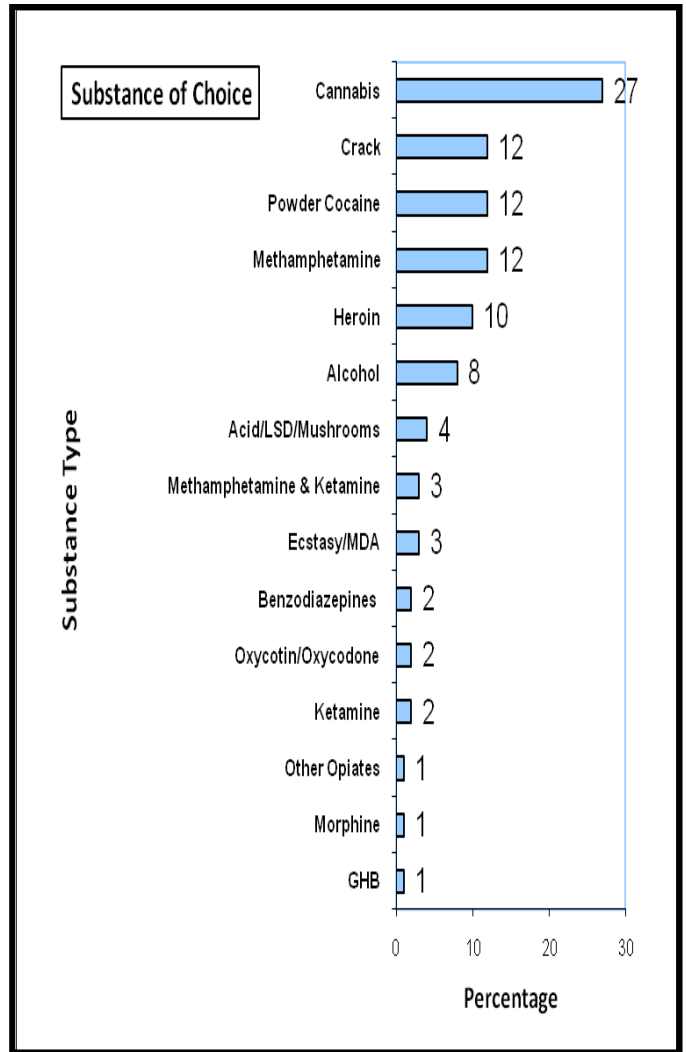
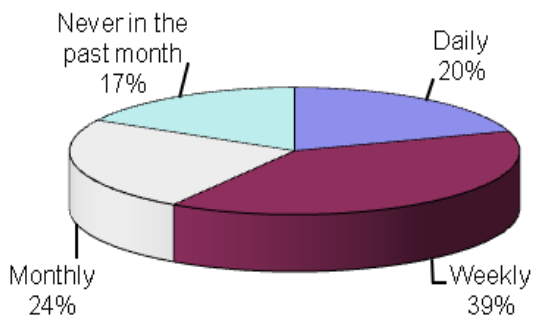
- 11% used methamphetamine every day (2 or more times a day)
- 8% used once daily
- 23% used regularly (3 to 4 times per week)
- 10% used regularly (once to twice a week)
- 21% of youth used infrequently (1 to 2 times per month)
- 27% used once a month

SUBSTANCE OF CHOICE

Though youth regularly used many substances, there were specific substances that youth preferred to use when they had access. In the past 30 days, 39% of survey respondents used their drug of choice on a weekly basis; 24% of a monthly basis; 20% on a daily basis; and 17% had not used their drug of choice. In the past six months, 48% had tried but were unsuccessful at cutting down or quitting their drug of choice.

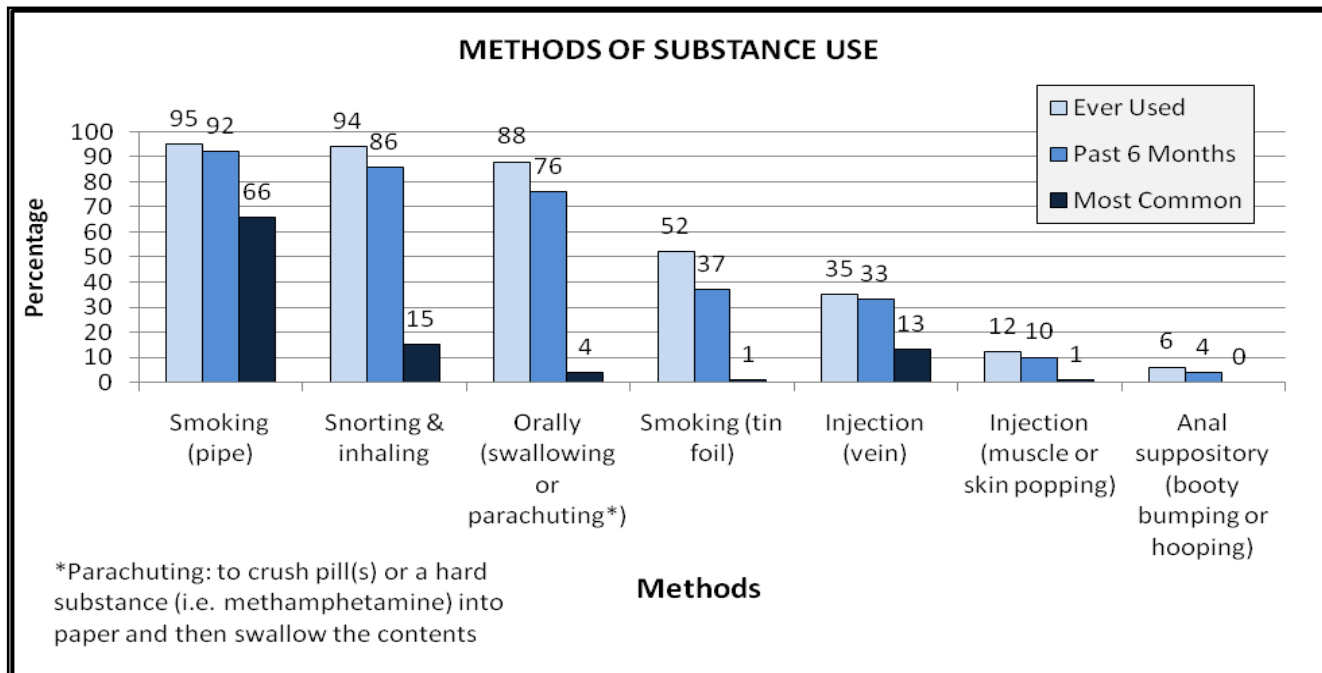
The following charts show survey respondents' drug of choice and frequency of use.

Frequency of Use of Drug of Choice



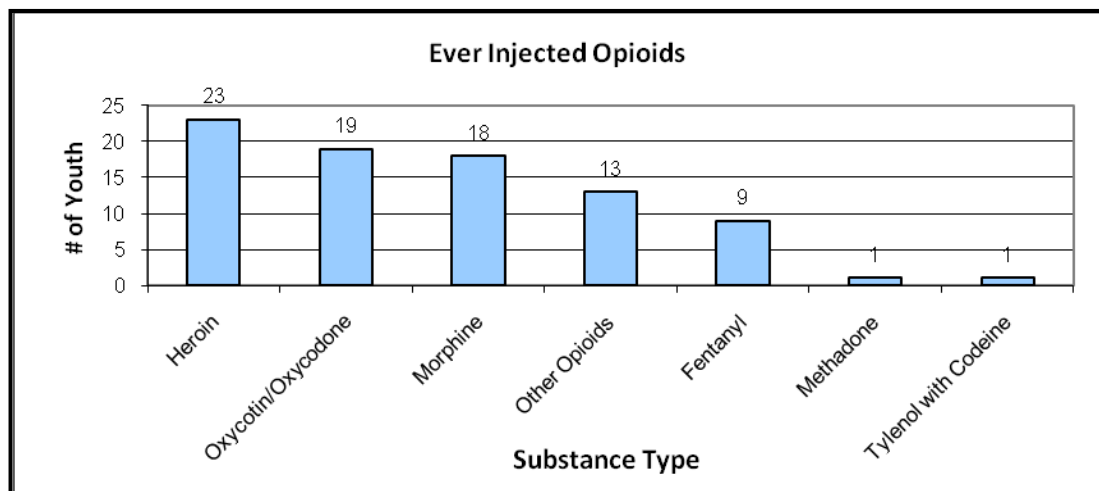
METHODS OF SUBSTANCE USE

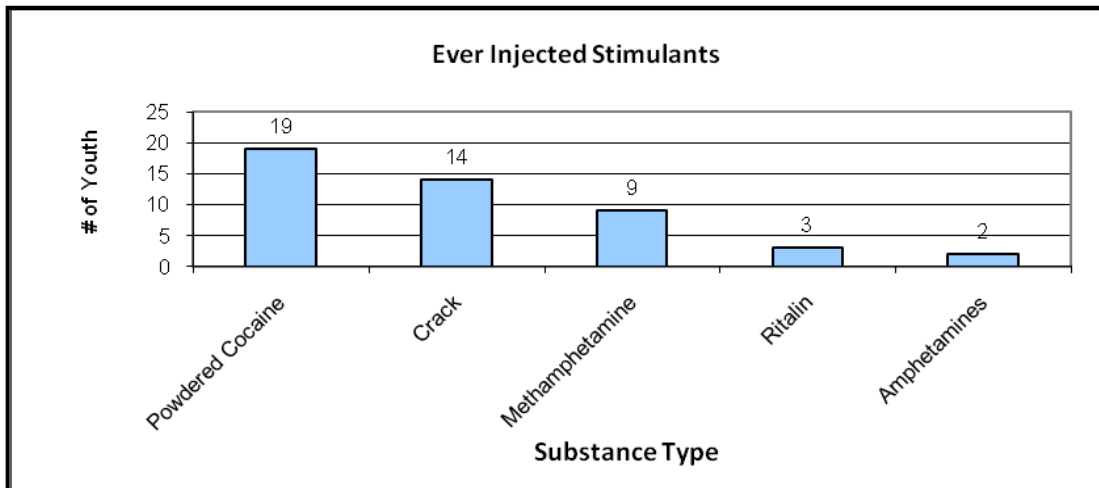
The following chart shows the methods of substance use survey respondents had ever employed, had used in the past six months and which methods they had used the most. Multiple responses were permitted.



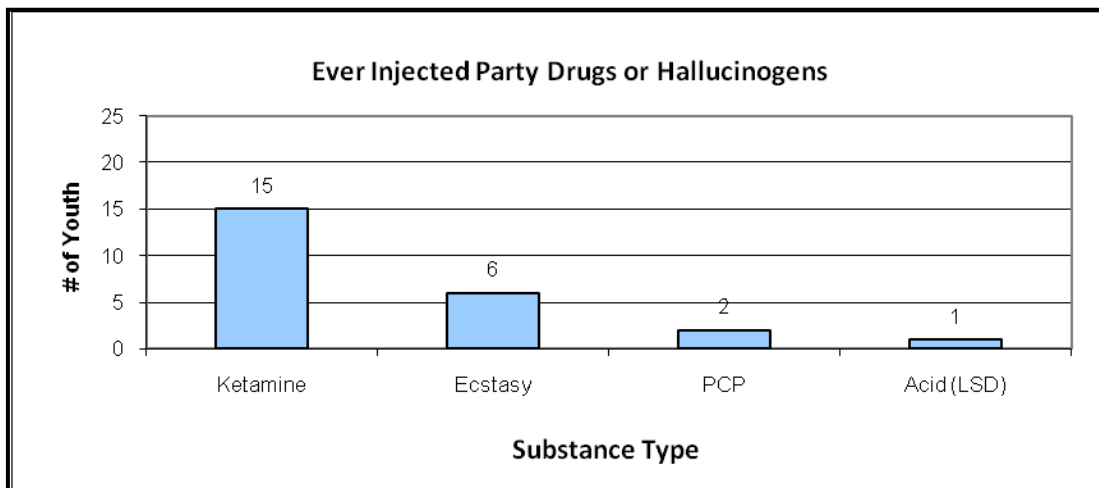
HISTORY OF INJECTION DRUG USE

While all methods of administration carry some risks, the most hazardous is injection drug use. The following charts illustrate the injection history of the total sample of survey respondents in regards to having ever injected opioids, stimulants, party drugs and/or hallucinogens.





“Never used a rig until I was in a shelter, my neighbour liked to inject heroin and that was my first time using a rig there and I did it every day for about two weeks.”



Of the 33 survey respondents who had injected in the past six months:

- 18% had first injected when they were 13 to 15 years of age
- 40% when they were 16 to 18 years of age
- 42% when they were 19 to 22 years of age.

Frequency of injection drug use:

- 3% injected 5 to 10 times a day

- 18% used 2 or 3 times a day
- 18% used once daily
- 9% used regularly (3 or more times per week)
- 12% used regularly (once to twice a week)
- 31% of youth used once in a while (not every week)
- 3% did not know how often they injected

REASONS FOR USING SUBSTANCES

“There’s a number of different reasons, like, there’s ten people in this room and everyone could have a different reason, like, me, I do drugs ‘cause I lost my kids, you know. Other people do drugs for different reasons, ‘cause they’re jobless...”

Survey respondents were asked why they used substances. Reasons were reflective of issues relating to coping, pleasure, dependence, escape and other aims.

The following table illustrates the general roles that substance use plays in youths’ lives. Multiple responses were permitted.

Reasons for Using Substances	%
To have more fun	88%
To socialize	78%
To have more energy	77%
To escape	74%
To stay up all night	63%
To sleep	59%
To feel more sexual/want to have sex	51%
To avoid withdrawal symptoms	50%
To feel safe	33%
To keep weight down/not want to eat	26%
To feel healthy	25%
It's part of my spiritual practices	19%

The following table illustrates the situations and issues in which survey respondents use substances as a coping mechanism. Multiple responses were permitted.

“I wouldn’t be thinking ‘oh I’m homeless. I don’t have a place to stay tonight.’ I’m high so it’s completely off topic.”

Coping: Reasons for Using Substances	%
Stress	86%
Emotional pain	81%
Boredom	81%
Physical pain	68%
Loneliness	66%
Homelessness	65%
Mental health issues/symptoms	41%
Illegal work	41%
Legal work	33%
Hunger	32%
School	23%
Other	2%

Focus group participants cited a variety of roles and purposes that substance use plays in their life. Most frequently, they discussed getting high as a way to deal with their life circumstances.

A majority of survey and focus group participants talked about using drugs to escape reality. Their realities include homelessness, mental health issues, histories and current experiences of violence and assault, poverty, stigma, discrimination and loss. For example, many talked about using stimulants to help them deal with staying up all night, using alcohol and

other drugs to keep warm in the winter, dull hunger pains, and fill in time.

“When you go to smoke a bowl of meth... the high that it gives you it’s almost like you’re in your own housing.”

Using drugs was referred to as a way to self-medicate – for physical and mental health issues. For youth dealing with depression, drugs are often used in order to forget about depression, anxiety and trauma issues. Others used substances to escape from or cope with being homeless, staying in shelters, social isolation and their involvement in illegal activities such as sex work.

“Because they’re homeless. Because they’re depressed. Because they don’t know how to deal with problems. Because they don’t feel loved, they feel lonely.”

For some of the youth, using drugs is a part of street-culture and social networks. They said that their peers have a lot to do with their drug use and that it’s hard to escape drugs when you are homeless or street-involved. Others have found using drugs was a way to disconnect from other people. Many also reported using drugs out of boredom and a sense of purposelessness and hopelessness.

“When I was sleeping on the street. You know, boredom would kick in... so, I have nothing to do so I’ll go smoke crack... and then it’s like... I have nowhere to sleep. I’m going to stay up all night, so let’s smoke some crack... or drink some alcohol to stay warm.”

For many young people, youth is a time period in which there is a lot of pressure to fit in and to physically reflect societal norms of attractiveness. One focus group participant spoke about body image issues and using substances in order to lose weight.

“I did it for weight loss, then to escape reality.”

Survey respondents were also asked if they ever used substances when they were expecting or wanting to have sex; 40% of respondents answered yes. The following table illustrates their reasons for doing so.

Sex: Reasons for Using Substances (n=40)	%
To enjoy sex more/make it feel better	85%
To loosen inhibitions	70%
To feel more attractive/sexual	55%
To make it easier to approach and meet sex partner(s)	53%
To have sex with people I usually would not have sex with	48%
To do sexual things I usually wouldn't do	45%
To be able to have sex when I don't want to	45%
To get an erection and keep it longer	43%
To have sex with people I don't know	38%
To not feel bad or guilty about bare backing (not using a condom)	30%
To get prepared for or to do sex work	23%

PLACES WHERE YOUTH HAVE USED SUBSTANCES

Like their sources of shelter, the youth we surveyed relied on a wide range of locations to use substances. In most cases these locations were very reflective of their sources of shelter and their social networks. These types of locations are often contributing factors in regards to overdoses, unprotected sex and conflicts with the law as well as unsafe drug practices, such as sharing substance use equipment, missed injections (i.e. they failed to locate a vein when they injected) and unhygienic injections, all of which may lead to infections.

The following table illustrates where survey respondents had ever used or injected substances in regards to homes and institutional facilities. Multiple responses were permitted

PLACES YOUTH HAVE EVER USED OR INJECTED SUBSTANCES			
GENRE	PLACES	Any Substance	Injection
HOMES	Friend's home	88%	27%
	Own home (alone or with others)	48%	18%
	Parent's home	21%	6%
	Relative's home	16%	1%
INSTITUTIONS	Hostels/shelters	55%	12%
	Drop-in centre	42%	11%
	School or school yard	32%	8%
	Detention centre, jail or prison	18%	24%
	Community health centre	11%	5%
	Transition house/halfway house	9%	1%
	Hospitals	8%	3%
	Detox centre/recovery house	5%	1%

“If you’re a needle user, you pretty much have to find a place indoors to do that, or at least under a bridge.”

The following table illustrates where survey respondents had ever used or injected substances in regards to indoor public spaces and outdoor spaces. Multiple responses were permitted.

PLACES YOUTH HAVE EVER USED OR INJECTED SUBSTANCES			
GENRE	PLACES	Any Substance	Injection
PUBLIC-INDOORS	Hotels/motels	58%	12%
	Public or business bathroom	58%	19%
	Club or bar	57%	5%
	Place to buy, sell or use drugs	51%	12%
	Circuit party or rave	39%	6%
	Workplace	28%	8%
	Bath house	16%	5%
	Sex party	13%	3%
	Restaurants, Laundromats, etc	7%	24%
OUTDOORS	Park	76%	16%
	Street, alley way or parking lot	71%	15%
	Stairwell	60%	13%
	In a car/other vehicle	55%	11%
	Abandoned building/squat	45%	15%

“You don’t want to be outside to do your drugs... you want to be in a stairwell, somewhere you can escape if someone comes.”

The following is a list of the most commonly used locations (i.e. youth’s top 3 locations):

- Friends place (51%)
- Parks (35%)
- Street, alley way and/or parking lot (33%)
- Their own place (21%)
- Stairwell (18%)
- Public or business bathroom (13%)
- Bathhouse (12%)
- Shelter/hostel; abandoned building or squat (11%)

As reflected in the responses, focus group participants have a strong preference for using indoors when this option is available as privacy is very important to them. Youth often referred to the fact that using outside is less favoured (though frequently necessary) because it leaves one exposed to being seen by police, workers, family, friends, future employers, teachers and the general public. Though most youth agreed that if someone wanted to get high, they will, regardless of where they are and what tools they have.

Most focus group participants indicated that housing status influenced what methods of drug use they chose. For example, it is much easier to be discreet smoking crack or methamphetamine as this method is quicker and easier to hide when using outside, than to inject or snort drugs.

“People do it just about anywhere. It’s very easy to punch rock quick times [smoke crack] and put your pipe back in your pocket.”

When using outside, youth choose to use in hidden places such as stairwells, under bridges, and alleys in order to avoid detection by police and the public. These locations pose specific types of risks because they do not offer sufficient time, space, light or cleanliness and access to water to be able to use safely. Many of the youth indicated that injecting or snorting drugs is much more difficult and riskier to do when using and living outside. Despite this many of the youth we surveyed had injected in outside and public locations. Youth spoke about specific risks and fears they faced when using substances outside versus indoors. Participants mentioned disease transmission (i.e. HIV/AIDS and Hepatitis C), violence, stabbings, and sexual abuse as risks they experienced when using on the streets.

“Everything comes down to having no safe place to do drugs or buy drugs. You’re out on the street.”

“Theft. Catching diseases. Friends backstabbing each other. It’s completely different than it was years ago.”

A consistent theme across all of the focus groups was how the choice of drug was made in consideration of the demands stemming from their living situations. For example, youth living on the street were more likely to use stimulants to stay alert whereas at home they would want to “mellow out” and therefore more likely to use cannabis, ketamine or opiates. In addition, some participants felt that using outside influenced the types of

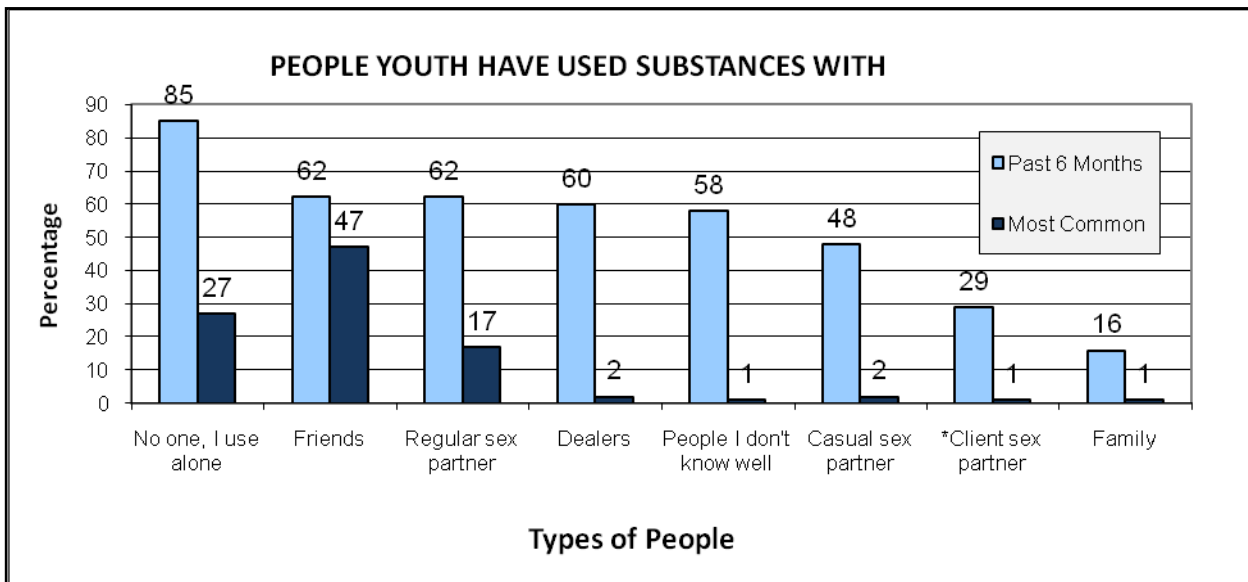
activities they engaged in; as well as their behaviour and/or how substances affected them.

“If I’m on the street I’m going to be up all night, so I might as well get the drug that keeps me up all night, and if I’m at home I want something that’s more chill, like weed or k [ketamine].”

“When I do drugs at home I just sit and sketch on my computer all night. Out here, our mind wanders and you wanna do stupid things.”

WHO YOUTH USED SUBSTANCES WITH

The following chart shows with whom survey respondents used substances in the past six months and the people they most commonly used with. Multiple responses were permitted.



*A client sex partner is defined as someone who has given money, drugs, etc, in exchange for sex.

Most survey respondents commonly used substances with their friends. Focus group participants reported being introduced to particular drugs and methods of using through their peers and people they met in the shelter system. For some, using substances is connected with belonging to particular communities and social networks; and is part of the community membership. In addition, many youth use with friends and people they trust as a strategy to reduce potential risks associated with substance use.

"I try to get high with people I love."

"If you're with people you know, it's safer"

The close connection between drug use and social networks make it more difficult for those who are considering cutting down or quitting drugs as this may threaten their membership in the community and their relationships with their peers.

"What makes it hard? The environment...I don't want to even stay at my house or like keep it... cause there's so many drugs there."

For some focus group participants, using drugs is a more private activity that they do on their own and is connected to feelings of shame and not wanting anyone to know. Among survey respondents there were high rates of using substances alone, which is a risk factor for overdoses (20% of respondents had experienced an overdose in the past six months).

"If you are going to do it, do it in private".

Using in a group setting can lower one's risk of overdoses but it can also elevate one's risk in regards to sharing drug use equipment, such as syringes, water, cookers, filters and crack pipes, as it is common for people to lose track of their own equipment.

KNOWLEDGE OF SAFER DRUG USE PRACTICES

Access to accurate knowledge of safer drug use practices is a vital component to ones' ability to practice harm reduction. Along with access, the quality of information that youth receive is also important.

All survey respondents were asked to rate their knowledge of safer drug use practices as excellent, good, fair or poor.

- 41% of survey respondents rated their knowledge as excellent
- 28% as good
- 25% as fair
- 6% as poor

Similarly, among the survey respondents who had injected drugs in the past six months:

- 34% of survey respondents rated their knowledge as excellent
- 38% as good
- 22% as fair
- 6% as poor

In general, survey respondents got their safer drug use information both in written or oral form and from a wide variety of sources. The following list illustrates these sources (multiple responses were permitted):

- 73% Brochures/booklets
- 72% Other substance users
- 69% Drop-in workers
- 62% Street outreach program
- 61% Health care providers (nurses and doctors)
- 60% Peer harm reduction workers
- 57% Shelters/housing workers
- 55% Harm reduction workers (not peers)
- 53% Counsellors
- 51% Internet
- 43% Addiction counsellor
- 37% Needle exchange programs
- 12% AIDS service organization



HARMS & RISKS RELATED TO SUBSTANCE USE

The expansion of existing harm reduction services and the development of innovative programs and strategies, as well as addressing the social determinants of health, are essential components to reducing and eliminating harms and risks associated with drug use. This section outlines the following types of harms and risks that survey and focus group participants experienced:

- Needing help to inject
- Injection related infections
- Unsafe disposal of used injection equipment
- Poly drug use
- Sharing drug use equipment
- Using homemade and toxic pipes
- Specific harms related to crack and methamphetamine use

NEEDING HELP TO INJECT

78% of the 33 respondents who had injected in the past six months had at some point in their lives required assistance when injecting (i.e. they relied on another person to inject them). At the time of the survey, 15% continue to always need someone else to inject them and 19% sometimes need someone else to inject them. Relying on others to inject increases one's vulnerability to HIV infections⁸.

⁸ In Vancouver, the HIV prevalence rate among people who need assistance injecting is double that of those who do not. Women are more than twice as likely as men to require assistance injecting.

INJECTION RELATED INFECTIONS

Injection related Infections are often due to the following factors: unhygienic injection practices (not properly cleaning the injection site and/or ones hands, using dirty water and re-using injection equipment); improper vein maintenance (i.e. missing the vein, digging for a vein and not properly rotating injection sites); and injecting "dirty shots" (i.e. injecting residue from a crack pipe, and/or from used filters).

Of the 33 survey respondents who inject drugs, 36% had experienced an injection related infection. They took a variety of approaches to treating the infection: 58% went to a hospital emergency department, 33% did nothing, 25% took care of it themselves and 8% went to a medical walk-in clinic. Of those that accessed a medical facility (n=8), they rated the quality of medical care they received as poor (63%), fair (25%) and good (12%).

DISPOSING OF USED INJECTION EQUIPMENT

When asked about disposing of used injection equipment, 48% of the 33 respondents who had injected in the past six months had discarded them in a biohazard container at a community agency, 30% had thrown them into a garbage can or toilet, 21% had returned them to a needle exchange program, 18% had thrown them away - in streets, sewer grates, parks or alley ways; 9% gave them to others to discard, 3% buried them in the ground, and 3% were still storing them in their home.



When asked to rate the importance of having an outside needle drop-off box (i.e. a secure biohazard container where one can only put items into it, not take items out), 74% of all survey respondents rated it as a high priority; 12% rated it as low and 14% rated it as no importance to them.

“Maybe there should be more biohazard containers outside, or even in a Wendy’s bathroom...that’s where most street-involved youth would be.”

POLY DRUG USE

Combining stimulants and depressants can be potentially lethal. The stimulant raises one’s pulse but its effects generally wear off more quickly than depressants, which in turn slow down the heart. As a result, the user may experience a delayed ‘overdose’ (i.e. respiratory depression) when the stimulant wears off and the full effects of the depressant are felt in isolation. 20% of survey respondents had experienced an overdose in the past six months; 11% required medical attention.

Survey respondents used combinations of stimulants and depressants (i.e. speedballs) such as powdered cocaine with heroin, heroin with crack, methamphetamine with Ketamine, and methamphetamine with GHB.

In regards to ever using these drugs together:

- 14% of survey respondents had used powdered cocaine with heroin together
- 15% had used heroin with crack
- 22% had used methamphetamine with Ketamine
- 17% had used methamphetamine with GHB

SHARING OF DRUG USE EQUIPMENT

There are many factors which influence drug equipment sharing practices, such as access to harm reduction distribution programs, access to harm reduction material for all methods of drug use,

stable housing, access to clean, well-lit and safe spaces to use drugs, poverty, discrimination, an individual’s mental and physical state, social networks, knowledge of safer drug practices, ability to manage one’s drug use and plan ahead, and so on.

Sharing snorting devices:

A snorting device is generally a straw, rolled up piece of paper or dollar bill which is used to snort drugs in their powdered form. Sharing snorting devices is a risk factor for Hepatitis C. Hepatitis C is a blood borne virus that is spread from person to person through infected blood getting directly into the blood stream (even small amounts not visible to the eye). Often when people are snorting repeatedly, the inside lining of their nose becomes irritated, which causes small amounts of blood to leak out. This blood gets transferred onto a snorting device which then gets used by other people, potentially infecting anyone who uses it.

86% of all survey respondents had snorted drugs in the past six months. Of those, 59% reported sharing a snorting device. 19% said that they occasionally (1/4 or less of the time) used a snorting device that had already been used by someone else; 22% said sometimes (1/2 of the time); 8% said usually (3/4 of the time); 9% said always (all of the time); and 1% didn’t know how often they had used a snorting device that had already been used by someone else.

When asked if they would use a safer snorting kit if a harm reduction distribution program (i.e. a needle exchange) made one available, 84% said they would.

Sharing injection equipment

Research has shown that higher risk needle sharing behaviours are associated with reports of injecting in semi-public areas (streets, rooftops, parks, cars, public bathrooms, and abandoned buildings). Often these environments provide poor lighting and no access to fresh water. If people are using in a group setting where lighting is poor and/or in a cramped space they may not be able to keep track of their own equipment, increasing their chances of using

someone else's syringe or a syringe that they have already used. In addition, due to the risk of being seen by the police, individuals may be in a rush to inject and may miss and have to re-inject, thereby increasing their risk of infection and vein damage.

Of the 33 survey respondents who injected substances in the past six months, 79% reported never injecting with a needle/syringe that had already been used by someone else. 21% had occasionally (1/4 of the time) used a syringe that had already been used by someone else.



In regards to using other injection equipment (water, filter, cookers/spoon, etc) that had already been used by someone else, 64% reported never doing so; 12% reported occasionally (1/4 of the time); 15% reported sometimes (1/2 of the time); 6% reported always (all of the time); and 3% refused to answer.

There were many reasons cited for sharing injection equipment, such as:

“When I first started using needles, I was sharing with my sister ‘cause I didn’t know the risks.”

- **Lack of access to sterile/clean injection equipment –program issues:** they didn’t know where to get injection equipment; there were no needle exchange programs near where they were hanging out and using substances; needle exchange was closed; couldn’t afford transportation to a needle exchange; local needle exchange doesn’t supply all of the injection equipment they needed (i.e. cookers, filters, ties and/or vitamin c); and at the time they were in a corrections facility

“Night time comes and it all shuts down. And then you don’t have anything so all right...I’ll use yours.”

- **Lack of access to sterile/clean injection equipment (other issues):** the police took their syringes and other works; their belongings were lost/stolen (including their injection equipment); syringes were too expensive to buy; and pharmacy wouldn’t sell them a syringe
- **Trust:** they were careful with whom they shared with; they “knew” the person they were sharing with was not infected with Hepatitis C and/or HIV/AIDS
- **Lack of knowledge:** they didn’t know that sharing other works was unsafe; they thought it was safe because they cleaned it
- **Unconcerned about risks:** they were too high to care about the risks; they thought they already had HIV/AIDS and/or Hepatitis C – so why bother
- **Unplanned drug use:** they didn’t have their own needles and other works and they wanted to get high
- **Using in a group setting:** they got their equipment mixed up with other peoples

The most common reasons for cited for sharing were the following:

Not having their own injection equipment and wanting to get high; needle exchange services not being available when needed; trusting the person they were using with; believing that cleaning injection equipment made it safe; got equipment mixed up; and not knowing about the risks of sharing equipment.

Lending used injection equipment

We also asked respondents how often the injection equipment (syringes and other works) that they had used to inject with was then used again by someone else. 22% reported that this happened occasionally (1/4 of the time), 19% reported sometimes (1/2 of

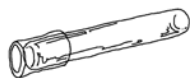
the time), 3% reported usually (3/4 of the time), 3% reported always (all of the time), 50% reported never and 3% refused to answer.

Sharing crack pipes

Of the 71 survey respondents who used crack in the past six months, 61% did so by smoking it in a pipe that had already been used by someone else. When asked how often this had happened, 26% reported occasionally (1/4 of the time); 18% reported sometimes (1/2 of the time); 10% reported usually (3/4 of the time); 13% report always (all of the time).

“People are going to still get high. If you gotta share pipe, that’s not going to change the fact.”

The reasons cited for sharing crack pipes were very similar to sharing injection equipment, such as:



- **Lack of access to a safer crack use kit distribution - program issues:** they didn’t know where to get a safer crack use kit; needle exchange program was closed; there are no needle exchange or safer crack use kit distribution program where they live, hang out or use crack; they couldn’t afford transportation to a needle exchange; they were barred from their local needle exchange.
- **Lack of access to a safer crack use kit:** the police took their pipe; their belongings were lost/stolen; pipes are too expensive to buy/rent.
- **Trust:** they were careful with whom they shared with; they “knew” the person was not infected with Hepatitis C
- **Social activity:** they share to have a connection with the person they are smoking crack with
- **Lack of knowledge:** they didn’t know that sharing pipes was unsafe; they thought it was safe because they cleaned it.
- **Unconcerned about risks:** they were too high to care about the risks; they thought they already had Hepatitis C – so why bother.

- **Unplanned drug use:** they didn’t have their own pipe and they wanted to get high.
- **Using in a group setting:** they got confused and their pipe got mixed up with other peoples pipes.

“... I always shared my crack pipe ‘cause I thought it was safe... I thought I couldn’t get sick from sharing a crack pipe and then I got Hepatitis C.”

The most common reasons cited for sharing were as follows:

Not having their own pipe and wanting to get high; trusting the person they were using with; being too high to care about the risks; lack of knowledge regarding the risks; and not having access to a safer crack use kit.

Lending, renting and selling used crack pipes

We also asked respondents if the crack pipes that they had used to smoke crack, were then used again by someone else. 57% of respondents reported lending, renting and/or selling their pipe to other people.

“It will never stop. When I used to smoke crack, you walk down the street and people ask if they can use your pipe.”

Sharing methamphetamine pipes

Of the 51 survey respondents who used methamphetamine in the past six months, 94% did so by smoking it in a pipe. Of those individuals, 81% used a pipe that had already been used by someone else. When asked how often this had happened, 19% reported occasionally (1/4 of the time); 12% reported sometimes (1/2 of the time); 13% reported usually (3/4 of the time); 33% report always (all of the time); and 4% didn’t know.

In Toronto, there is currently no safer methamphetamine pipe kit distribution program available; thus, we did not ask methamphetamine users why they shared their pipes.

Lending, renting and selling used methamphetamine pipes

We also asked respondents if the pipes that they had used to smoke methamphetamine, were then used again by someone else. 47% of respondents reported lending, renting and/or selling their pipes to other people.

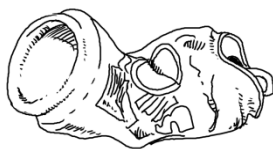
THE USE OF HOMEMADE AND TOXIC PIPES

Smoking Crack

We asked survey respondents who used crack what types of pipes they had used in the past six months. Many of the respondents had used more than one type of pipe. 74% had used an official safer crack use kit⁹, from a safer crack kit distribution and/or needle exchange program.

Despite the availability of safer crack use kits, there is still wide use of homemade and toxic pipes; as well as pipes made from inferior glass purchased from black market sources (i.e. dealers, convenience stores) and other people who use drugs. 61% of survey respondents who smoked crack had used a stem not from a safer crack kit distribution and/or needle exchange program. 56% of survey respondents had used a pop can; 50% had used a ginseng bottle; 29% had used a copper pipe; and 26% had used a plastic bottle and/or an asthma inhaler for a pipe.

“You’re spending your money on drugs and you know you can make something out of a can or whatever it may be.”



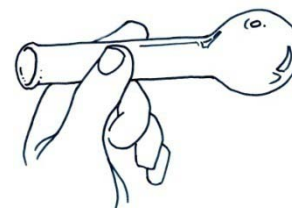
Frequent crack smoking and the use of homemade and toxic pipes is associated with specific harms such

⁹ Most kits contain one or two Pyrex stems/pipes, metal screens, a shortened chopstick (to push the screens in place), alcohol wipes, lubricated condoms and matches. Some kits also include lip balm, chewing gum, mouth piece and/or BZK wipes.

as burns, cuts, lesions and other injuries to the mouth, lips, hands; and respiratory system. These harms are due to pipe materials having sharp metal and/or glass edges which are often jagged; pipe materials becoming extremely hot when used; and the inhalation of toxic fumes and particles from heated pipe material (plastic, metal, cigarette ash and water). These harms in combination with sharing pipes increase ones’ risk for Hepatitis C, HIV, STI’s, and respiratory illnesses.

Smoking Methamphetamine

We asked survey respondents who had smoked methamphetamine in the past six months, what types of pipes they had used. The majority of respondents (83%) used a glass pipe, often referred to as a rose or oil pipe. In general, these pipes have a glass stem, open on one end and a bowl on the other end with a small hole on top. The methamphetamine is placed in the bowl through the hole and then heated up from the bottom. 40% used a homemade pipe made from a light bulb; 21% smoked it using tin foil, 19% used a crack pipe and 8% used a metal pipe. As well, individuals used bubblers (small pipes which use water) and homemade pipes made from asthma inhalers.



To make a pipe using a light bulb, the brass contact is removed and the wires leading to the filament are broken. Once the contact has been pulled out, one then cracks the glass insulator (the chips from this are quite pervasive and razor sharp); then they break the fill tube and shake the filament assembly out of the tube. Inside the bulb are sharp pieces of glass and a powder (kaolin), which is then removed. The drug is then placed inside the bulb, heated up from the outside, and the smoke is inhaled through the socket end using a hollow hard plastic or glass tube or rolled up paper. Specific harms associated with using a light bulb as a



pipe are similar to those of a homemade ginseng pipe, such as burns, cuts, other injuries to the mouth, lips and hands due to rough jagged edges and thin glass that heats up quickly. Inhalation of fumes from not carefully cleaning the inside of the bulb may also cause respiratory harms. Focus group participants cited various reasons for using a light bulb to smoke methamphetamine, such as availability and low-expense.

“Say you are in a bath-house and they don’t always allow you to go in and out so you go around, find a light bulb and make your own pipe. It’s cheaper.”

HARMS ASSOCIATED WITH CRACK

The following table represents harms experienced in the past six months by survey respondents who had used crack.

Harms Associated with Crack Use (n=71)	%
Drug induced psychosis, paranoid delusions	58%
Difficulty breathing ¹⁰	57%
Cracked lips	49%
Burns and cuts to the hands	46%
Burns and cuts to the lips	35%
Pieces of screen/Brillo® ¹¹ stuck in throat	35%
Burns and cuts on the tongue	23%
Sores on the lips or tongue	23%
Seizures ¹²	8%

¹⁰ In the past six months, 23% of survey respondents had been diagnosed with and/or treated for a respiratory illness, 23% were concerned about a respiratory illness but had not been diagnosed or treated.

¹¹ Steel wool

¹² Crack use can provoke a seizure or exacerbate a pre-existing seizure disorder, often due to using more than a person can psychically tolerate.

HARMS ASSOCIATED WITH METHAMPHETAMINE

The following table represents harms experienced in the past six months by survey respondents who had used methamphetamine.

Harms Associated with Methamphetamine Use (n=51)	%
Hallucinations (audio or visual)	55%
Drug induced psychosis, paranoid delusions	53%
Cracked lips	35%
Burns and cuts to the hands	35%
Picking and digging skin causing open cuts and sores	35%
Burns on or in the nose (nasal openings)	26%
Burns and cuts to the lips	18%
Nose bleeds	16%
Sores on the lips	14%

In addition, some focus group participants reported experiencing adverse changes to their behaviour when using methamphetamine.

“Tina [methamphetamine] changes your whole personality. That shit makes you go crazy. Completely changes who you are.”

WHERE YOUTH GET HARM REDUCTION SUPPLIES



Along with where youth get their supplies, who they get them from is also important. Some focus group participants spoke of being more comfortable getting harm reduction supplies from people who are involved in drug-related activities (e.g. drug dealers, people who use substances). This is also reflected in survey and focus group participants stated preference of interacting with peer harm reduction workers and staff with lived experience.

“If you’re not comfortable asking for it, you’re not going to go up to them [outreach workers].”

“They’ll go to people... involved in drug activity, whether it’s a pharmacist or your friend or whatever... you’re going to go where drugs are familiar.”

INJECTION EQUIPMENT

In the past six months, survey respondents who inject substances relied on numerous sources for their injection equipment:

- 73% got their supplies from an on-site needle exchange program

- 70% got them through a friend(s) and/or sex partner(s)
- 52% from a street-outreach or a mobile needle exchange program
- 48% from a pharmacy
- 30% from a drug dealer
- 12% from people they didn’t know
- 3% refused to answer the question

46% of survey respondents reported that the source they relied upon the most was an on-site needle exchange program, 24% pharmacy, 18% friend(s) and/or sex partner(s), 3% street outreach or a mobile needle exchange, 3% drug dealer, and 6% didn’t know.

In regard to how often respondents accessed the services of a needle exchange program for injection equipment:

- 21% reported never using one
- 9% occasionally (1/4 of the time)
- 24% sometimes (1/2 of the time)
- 27% usually (3/4 of the time)
- 15% always (all of the time)
- 3% refused to answer

When asked how often they used other means to get their injection equipment (such as a pharmacy, drug dealer or friends), 18% reported never using other means, 24% occasionally, 21% sometimes, 21% usually, 13% reported always, and 3% refused to answer.

SAFER CRACK SMOKING EQUIPMENT

In the past six months, survey respondents who smoked crack relied on numerous sources for a crack pipe:

- 64% got a safer crack smoking kit from an on-site needle exchange program
- 59% from a friend(s) and/or sex partner(s)

- 52% from a convenience store
- 42% from a street-outreach or a mobile needle exchange program
- 32% from a drug dealer
- 26% from people they didn't know
- 1% from a drop-in/shelter

In regards to how often respondents accessed the services of a needle exchange program for a safer crack use kit:

- 29% reported never using one
- 25% occasionally (1/4 of the time)
- 13% sometimes (1/2 of the time)
- 19% usually (3/4 of the time)
- 11% always (all of the time)
- 3% didn't know

33% of respondents reported that the source they relied upon the most for a crack pipe was an on-site needle exchange program, 23% relied upon convenience stores selling black market pipes, 21% on friend(s) and/or sex partner(s), 7% street outreach or a mobile needle exchange, 5% a drug dealer and 4% people they didn't know, 5% other, and 2% didn't know.

When respondents were asked how often they used other means to get a crack pipe (such as friends, dealers and convenience stores), 10% reported never using other means, 27% occasionally, 19% sometimes, 21% usually, 22% reported always, and 1% didn't know.

Black market pipes are often purchased from people who access needle exchange programs and then sell safer crack use kits for a profit to convenience stores and individuals (e.g. dealers and people who smoke crack). As well, some stores sell pipes made from inferior glass. Relying on sources other than a needle exchange or harm reduction distribution program potentially places vulnerable individuals at an increased risk for harms and exploitation. In

addition, by relying on these types of sources, youth lose the opportunity to access supports, services and education offered through harm reduction programs.

PERSONAL STRATEGIES TO REDUCE RISKS

“Desperate Times Call for Desperate Measures.”

We asked focus group participants about their personal strategies to reduce and eliminate risks they faced when harm reduction services were not available to them (i.e. the needle exchange was closed or too far away).

Many participants had developed strategies to manage these situations, some of which reflect considerable awareness about disease transmission and potential harms and risks of substance use. Others revealed a sense of desperation, a lack of knowledge and a considerable amount of misinformation. Attempts to use with people they knew and trusted were repeatedly cited as the main strategy used when they are unable to access needle exchanges or distribution centres.

“If you're with people you know, it's safer.”

Strategies to reduce transmission of infections ranged from highly effective (planning ahead and stock piling new and sterile supplies) to less effective (bleaching kits) to ineffective, inaccurate, and potentially dangerous (sharing with a family member, using light bulbs, burning the end of the pipe to kill germs).

“Say you're closed Saturday and Sunday, pickup needles, Friday, Monday, Tuesday, Wednesday, Thursday and then pick up on Friday again so you have enough needles for a week.”

“The reason why you smoke meth in a light bulb is 'cause its cleaner, it's the cleanest of smoking, and you get higher.”

Youth acknowledged that risks were different depending on the drug and method of consumption. Some discussed smoking instead of snorting or injecting, though they mentioned this made it harder to switch back to smoking if you were used to snorting and injecting.

Youth demonstrated knowledge of resources to access clean sterile injection equipment and other types of harm reduction supplies after hours, such as hospitals, pharmacies, street outreach and mobile services (i.e. Toronto Public Health's program the Works) and shelters which operate harm reduction programs (i.e. Eva's Satellite).

As well, youth cited educational resources such as The Sharp Shooter booklet¹³ as successful health promotional tools to educate people on safer injection practices.

"I read a pamphlet that gave a very detailed explanation about how to use a rig [syringe] and when I picked up my first rig kit I didn't know how to use it and instead of destroying my arm by missing, and missing it gave me detailed info."

Focus group participants spoke of using their social networks to share information regarding strategies such as stockpiling and stashing supplies in multiple locations they frequent as a means to maintain a secure supply of injection equipment and pipes.

"I would stash needles around rooftops and stuff so at night if I needed one I could go to my stash spot."

Some participants were able to choose to avoid taking a risk by going to sleep rather than continuing to use. Many participants recognized that for some

homeless youth, choosing not to get high due to a lack of clean and sterile drug equipment would be a difficult challenge.

"It's there. The rush is there and your body wants it."

"You would probably think of things but not necessarily do them... nine times out of ten they are going to use what they have."

¹³ The Sharp Shooter booklet is a comprehensive booklet with information on safer injection practices and vein care, developed by injection drug users for injection drug users. Published in partnership with Central Toronto Community Health Centre

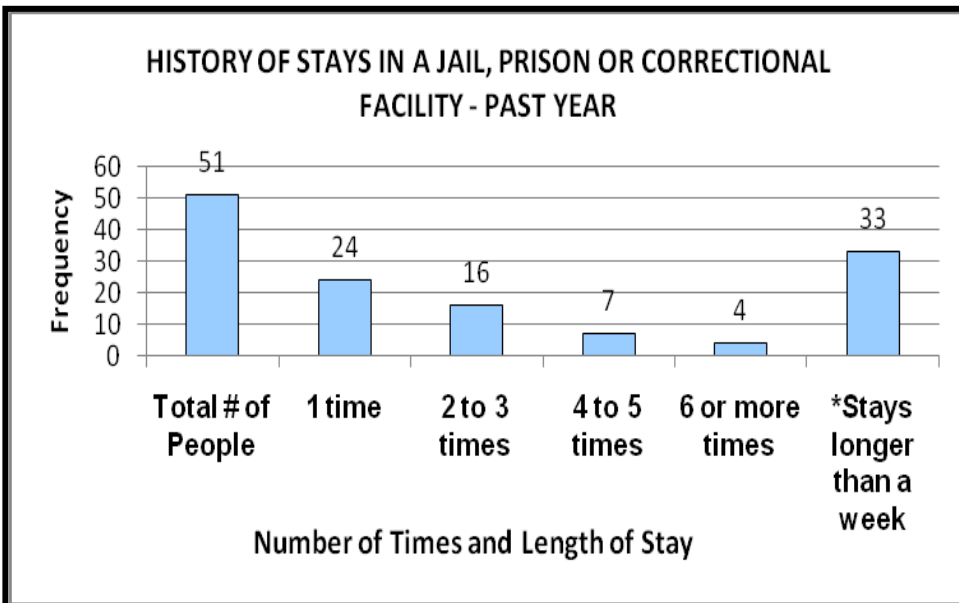
CONFLICTS WITH THE LAW



HISTORY OF IMPRISONMENT

When asked about their sources of shelter, 24% of survey respondents had spent a minimum of one night at a detention centre, 35% at a jail or prison and 47% at a police station.

The following chart illustrates how many survey respondents had stayed in a correctional facility in the past year, how many times this occurred and how many of those stays were for periods longer than a week.



While there may be programs operating in various types of correction facilities, they do not necessarily offer continuity of care. One focus group participant

described the mental health treatment given to him while in custody as a “medical trial”. Another made this plea:

“Tell the jails to stop screwing with our minds.”

In contrast another focus group participant had this to say regarding his stay in a penitentiary¹⁴.

“I did almost three years in the penitentiary for my best friend. I did a lot of thinking and growing up in there... I think the pen saved my life. I think I’d be dead or I don’t know where I’d be if I hadn’t...”

As well, discharge planning is not offered to those who are on remand custody (i.e. in custody while awaiting trial or sentencing). Many homeless youth who use substances find themselves caught in a cycle of ending up back on the streets or in shelters after being released. In addition, individuals with health issues which require on going medical treatment are often released without medication, or the means to acquire medication (i.e. money, drug card or referral), access to primary health care, ID (if they had any), housing and basic needs such as clothing.

While incarcerated, youth continue to be exposed to drugs and violence. In fact many youth continue to use drugs on either an occasional or regular basis throughout their sentence. In addition, current drug detection practices have inadvertently created an environment in which injection drug use has become more commonplace leading some youth to

¹⁴ Penitentiaries are for individuals serving 2 years or more; they offer a greater range of programs and services than those offered in jail.

engage in risky drug use behaviours while imprisoned (i.e. sharing injection equipment). For example, 24% of survey respondents had injected while in a correctional facility. Focus group participants agreed that there needs to be more treatment programs available for people as an alternative to jail.

“If you get arrested for having possession of drugs... you shouldn’t be given you know, 60 days in jail, you should get sentenced to rehabilitation.”

POLICING ISSUES

Getting into conflict with the law is a risk of being homeless, street-involved, using drugs and involvement in illegal activities. Keeping in mind all of the potential risks that homeless youth face, community policing issues are an important factor in regards to safety issues. When using a four pillar approach to substance use issues¹⁵, the police have the potential to act as a source of protection and a bridge to supportive services and referrals. This section explores youth’s experiences and perceptions in regards to positive and negative interactions with the police.

“The police are supposed to be there as an authority figure and they’re supposed to be there to help you out and if you’re being assaulted by them you’re not going to trust anybody.”

Interactions with individual police officers:

We asked both survey respondents and the focus group participants about their experience with the police. The following table depicts both the positive and the negative interactions youth had with *individual* police officers in the past six months, as reported in the survey.

Interactions with Individual Police Officers	%
Treated youth with respect and kindness	45%
Offered youth information	43%
Offered youth assistance	38%
Offered youth protection	30%
Taken youth's drug use equipment	45%
Assaulted youth	48%
Threatened youth with physical and/or sexual violence	53%
Gave youth a ticket/fine	55%
Behaved aggressively towards youth	70%
Harassed youth	85%
None of the above	23%

When asked about interactions with individual police officers, focus group participants had these comments to make in regards to positive interactions with the police.

“...I’ve had a couple of police officers who were really respectful to me and had long conversation with them... they were nice and I was like, cops can be nice?”

“The police in general are usually understanding and helpful but some of them have a really tinted view on youth on the street, right?... If they were respectful towards us, we’d be respectful towards them and if they’d help us maybe we’d help them.”

In addition to positive experiences, focus group participants also shared their negative experiences. The following sections outline community policing

¹⁵ A four pillar approach to substance use issues includes harm reduction, prevention, treatment and enforcement working collaboratively.

issues from the perspective of focus group participants.

Confiscation of harm reduction supplies:

A frequent concern voiced by participants was the practice of some police officers taking away their safer drug use supplies. Many expressed frustration that the very people who are supposed to protect them do not. They believe that police should support their positive and safer choices and efforts to reduce harms to themselves and others through the use of safe clean tools. Instead, taking away their drug use supplies exposes them to greater risks (i.e. sharing of injection equipment) and makes them less trusting of people.

“The police, they seem to pick on street-involved people and uh, people who that they know their [the police] word is worth way more... they’re not going to go to a lawyer guy and do the same shit they do to us...”

As well, many youth talked about receiving fines as a form of harassment. Failure to pay fines can result in a warrant for arrest if an individual has been repeatedly warned to pay them.

“I got a trespassing ticket for sitting on Yonge Street. Not one but two. They both came and gave me two tickets for two reasons.”



Art work by Dicky

“It’s a policeman’s job to protect you but when you’re taking someone’s drugs from them and their equipment it’s not really protecting them.”

Target Policing:

Focus group participants spoke passionately about their feelings and experiences of being targeted by the police. Most felt that this was due more to their marginalization and appearance rather than what they were doing or their involvement in criminal activities.

Discrimination:

Youth also reported experiencing discriminatory treatment in the form of racist and homophobic epithets based on their sexual orientation and gender identity.

“There seems to be homophobia through a lot of cops. I was in a bad situation... the guy [the police officer] came and started screaming and yelling; calling me a fag and a tranny (I wasn’t even a tranny at the time, P.S.)”

Physical assaults:

39% of survey respondents reported being assaulted by a police officer. Assaults by police were reported to be much more violent in nature and due to the inherent power imbalance categorically different from assaults from other people.

“I don’t have a problem with cops arresting me. More robbing me. I got robbed by three cops at Church and Wellesley... they divided it [money and drugs] up between them in front of me and then they assaulted me.”

Ineffectual police complaint process:

Focus group participants voiced tremendous frustration, hopelessness and injustice in regards to their attempts to submit an official complaint against individual police officers. Due to their experiences with the complaint process, youth feel that they do not have recourse when they have been mistreated. In addition, youth are fearful of retaliation in response to submitting a complaint as complaints are investigated by officers in the same division as the officer they are complaining about. One positive change is that as of October 2009, Ontario officially opened the Office of the Independent Police Review Director (OIPRD)¹⁶. With this change in the police complaint process youth may experience a shift in regards to equity and in their encounters with individual officers.

“There’s no way to hold cops more accountable... Really if something does happen and you do make a complaint and it does go to internal affairs, and I have done this, and really you go to court and it’s the cop’s word against yours and you’re a criminal with a record.”

“When the cops beat me up there was really nothing I could do about it because what I worried about if I actually did say something they would bring my ass down to Cherry Beach... I just left it alone ‘cause I was afraid of them.”

In response to these issues, youth gave a number of recommendations to improve relationships between homeless youth and the police. For more details, refer to the recommendations section of this report.

“Maybe just talk with the police about how they deal with us.”

It’s important to note that these types of unsatisfactory even violent interactions with police have been documented in prior studies¹⁷ and that the situation does not appear to have improved or changed dramatically.

¹⁶ The OIPRD is an independent agency (staffed entirely by civilians) of the Ministry of the Attorney General responsible for receiving and dealing with all public complaints about the police in Ontario. For more information visit <https://www.oiprd.on.ca/CMS/Home.aspx>

¹⁷ Gaetz, Stephen (2002) Street Justice: Homeless Youth and Access to Justice, Justice for Children and Youth.

SOCIAL STIGMA

Youth face stigma and discrimination related to many aspects of their lives such as their race, ethnic background, sexual orientation, gender identity, age, housing status, mental and physical health status, history of imprisonment, level of education, poverty, family history, as well as their use of substances.

“People think we are trash, basically. People jump right to conclusions... because you are doing drugs; you’re the scum of the earth.”

We asked focus group participants about their perception of other people’s attitudes about them and the impact (positive or negative) these attitudes have on them. Participants stated strongly the negative impact of social stigma and discrimination by members of the community and by professionals such as community workers, health care professionals, and law enforcement. Strong words such as “trash”, “scum”, and “useless” were used by the youth to describe how they see themselves as perceived by the public.

“They’re definitely prejudiced against us, they think we have no future, there’s no hope for us.”

“They’re no good. Street trash. They should all be put in jail.”

“Everyone has human rights but we’re drug addicts so we don’t have shit.”

“Not trustworthy. Not respectful”

“They think: ‘ you’ve made your bed...’”

“You’re stupid... dirty... useless”

Youth also shared positive experiences they have had with people.

“Some people think of us as scum, but others see through it.”

“Some people have good remarks, there are some really nice doctors I’ve seen... depends who the person is and on their mentality”

A number of participants perceived a difference in the way people respond to adults who are employed and use drugs versus homeless and/or street-involved youth. They also pointed out the continuum of social acceptability depending on the type of drug, the housing status, and income level.

“I know a lot of higher class people with good jobs, good paying money and they party just as bad as I do. But their whole perspective on it is completely backwards. How you gonna look at me one way but you are doing the exact same thing?”

“Depends on the drug you’re doing. Ecstasy and coke, that’s totally normal. Crack and meth – that’s not a normal thing.”

Participants generally agreed that negative attitudes from others led to poor self-image and self-care as well as more risk-taking activities. Many expressed internalized negative stereotypes of street-involved youth. Shame, poor self-esteem, and hopelessness characterized many of the narratives voiced by participants.

“I have this attitude when I see people doing crack. I have the exact same attitude that the public has. I’m like disgusting, like, ew... and I know how it feels. When I’m sketched out and I’m on my seventh or eighth day of being up... I sit there and I know these people are thinking the exact same way. And I don’t know. It hurts. Regardless. They’re seeing the thing the drug does to you, they’re not seeing who you are.”

“You get more depressed and do more drugs.”

I would think people are watching me, people are judging me, even people on the street car are looking at me. Now I just don’t care.”

A few of the youth spoke of their resistance to the negative labels and judgments.

“They classified me as an unfit parent. They told me... I’m not a good mother. But you have to look at it that whatever they think about you is what they think.”

“I don’t care. If you’re going to judge me, then I don’t got the time for you.”

Another impact of social stigma was on youth’s ability to form trusting relationships and to seek out help. Because of this, many youth look to themselves, are careful with whom they share information, and refrain from seeking help from others. Some focus group participants spoke of this as a way to maintain an image of strength, to prove that they are not weak or vulnerable. Others hardened themselves against the discrimination and abuse they are met with by trying to not care what other people think.

“I don’t want people to know”

“It’s hard to trust anyone because, like I said, any drug is illegal.”

“Makes me angry if I start to think a worker thinks negatively. They’re supposed to be open-minded and respectful. It’s kind of degrading... It makes you kind of angry.”

“We don’t want society or the community to look down on us so we just don’t reach out for the help.”

HEALTH ISSUES

Although youth typically tend to be healthy, homeless street-involved youth tend to be in poorer health, have higher rates of chronic, acute and episodic health issues than youth who are well-housed.

Street youth are exposed to a number of factors that may detrimentally affect their health, including inadequate shelter, poverty, poor diet, unsafe sexual practices, drug use, and exposure to violence, low levels of social support, and limited access to medical care.¹⁸

The figures throughout this section refer to the total 100 youth sampled.

PHYSICAL HEALTH CONDITIONS

We asked survey respondents if they had ever been diagnosed or treated for; or concerned about a range of physical health conditions. The table to the right displays their responses in regards to chronic or ongoing health conditions. Multiple responses were permitted.

Chronic or Ongoing Health Conditions	Diagnosed or Treated	Concerned Undiagnosed
Respiratory illness	23%	23%
Foot problem	14%	11%
Sexually transmitted infection (excluding HIV/AIDS and Hepatitis)	11%	12%
Hepatitis C	6%	12%
Anemia	6%	9%
Seizures	5%	6%
Eating disorder	3%	8%
Other liver problem (not hepatitis)	1%	17%
HIV/AIDS	1%	11%
Arthritis	1%	0%
FAS (fetal alcohol syndrome)	1%	0%
Hypoglycemia	1%	0%
Diabetes	0%	15%
Tuberculosis	0%	7%
Hepatitis B	0%	4%

¹⁸ Regional Public Health Department, Infectious Diseases Unit, Montreal, QC; and Centre for Clinical Epidemiology and Community Studies, Sir Mortimer B. Davis – Jewish General Hospital, Montreal, QC.

We also asked survey respondents to rate their physical health. The following table displays their responses:

Self-Rate of Physical Health (n=100)

Excellent	23%
Good	29%
Fair	30%
Poor	17%
Don't Know	1%

With 47% of survey respondents rating their physical health as fair to poor, it is no surprise that 25% of all survey respondents reported self-medicating with licit and illicit drugs in order to feel healthy.

HIV/AIDS AND HEPATITIS C

79% of respondents had been tested for HIV/AIDS. 62% had been tested between February 2008 and December 2008.

72% of respondents had been tested for Hepatitis C. 51% had been tested between March 2008 and December 2008.

When asked about the risks they faced when using substances outside and in other unsafe locations, focus group participants voiced concerns about getting infected with Hepatitis C or HIV/AIDS. These concerns were echoed by survey respondents.

21% of survey respondents were extremely concerned about HIV/AIDS, 12% were quite a bit concerned, 11% were moderately concerned, 17% were a little bit concerned and 39% were not at all concerned.

13% of survey respondents were extremely concerned about Hepatitis C, 15% were quite a bit concerned 4% were moderately concerned, 22%

were a little bit concerned and 46% were not at all concerned.

POOR NUTRITION AND FOOD SECURITY

We asked survey respondents to rate how well they ate on a daily basis. 16% rated their diet as excellent, 34% said good, 34% said fair, and 16% said poor.

- 13% reported being diagnosed and/or treated for a health problem related to poor diet
- 15% were concerned about their poor diet but had not been treated or diagnosed
- 3% had been diagnosed with an eating disorder and 8% were concerned but not diagnosed
- 26% reported using drugs to keep their weight down and/or to not want to eat

Going hungry:

52% reported going hungry in the past seven days because they couldn't afford food. For 12% of those individuals, this occurred on one day in the past seven days; 36% reported it occurring two days; 26% reported it occurring for 3 days; 6% for four days; 2% for five days; and 16% reported going hungry every day in the past seven days because they couldn't afford food. In addition, 32% of all respondents reported using drugs to cope with hunger.

“On the weekends there’s nothing to eat so you think, ‘well fuck it’ and you’ll take a hit of whatever you can get your hands on.”

Focus group participants spoke of purchasing food as being secondary after purchasing drugs for many youth struggling with substance use issues. As well, many youth felt that there is a lack of options for getting food on weekends and at night, times when youth most need it.

SLEEP AND EXHAUSTION

19% of survey respondents had been diagnosed and/or treated for a sleep disorder. 59% of all

respondents reported using drugs to sleep; 77% to have more energy; and 63% to stay up all night.

DENTAL CARE

Street youth are plagued with poor oral health; and the longer a youth is street involved, the greater likelihood that they will experience dental disease and gingival problems. In addition, street-involved youth's oral health is negatively impacted by substance use. In general, street-involved youth face numerous barriers to accessing even the minimum level of dental care. This is due to various factors such as poverty and discrimination. For instance many dentist offices do not accept people on social assistance. Only 24% of the survey respondents had seen a dentist in the past 6 months.

"... So many people have trouble with their teeth. Especially if they're doing drugs. Like how many people have you seen on the street who don't have any teeth? ... Because it costs you three, four, thousand dollars to get a fucking tooth."

"They won't take my drug card, they won't take me because I'm on welfare. Why won't you place me on a waiting list? And then I sit here hoping someone will cancel their dental appointment."

CHRONIC PAIN

Many youth we interviewed are coping with a variety of chronic pain issues, some of which may be related to disabilities and medical conditions that may not have been acknowledged, diagnosed and/or properly treated. In addition, it has been well documented that experiences of pain and inadequate access to pain management are common among people who are homeless. Among survey respondents, 68% reported using drugs in order to cope with chronic pain. 16% of respondents have been diagnosed and/or treated for chronic pain, 27% were concerned about chronic pain but had not received a diagnosis. 14% had been diagnosed and/or treated for chronic foot pain, 11% were concerned. 8% had been diagnosed and/or treated

for chronic headaches; 9% were concerned about chronic headaches.

LEARNING DISABILITIES

33% of Survey respondents reported being diagnosed with Attention Deficit Disorder (ADD, ADHD); 16% were concerned but had not been diagnosed. 20% had been diagnosed with a learning disorder other than ADD/ADHD, 15% were concerned but had not been diagnosed.

MENTAL HEALTH, TRAUMA AND STRESS

Mental Health

We asked survey respondents to rate their mental and emotional health. The following tables display youths' self appraisal of their mental health and emotional health.

Self-Rate of Mental and Emotional Health (n=100)

Excellent	8%
Good	27%
Fair	33%
Poor	26%
Refused	2%

When asked about the mental health history, 37% of survey respondents disclosed that they had been diagnosed and/or treated for a mental health condition; 30% were concerned but had not been diagnosed. Depression was the most common mental health issue reported; followed by bi-polar disorder, anxiety and schizophrenia.

41% of all respondents reported using drugs to cope with mental health issues and symptoms. 81% used drugs to cope with emotional pain.

“A lot of Depression...drugs is an easy way to not have to think about it.”

A large number of respondents experienced drug-induced psychosis, paranoid delusions and hallucinations.



- 42% of the respondents who had used crack in the past six months had experienced hallucinations
- 58% had suffered from a drug induced psychosis and paranoid delusions
- 55% of respondents who had used methamphetamine in the past six months had experienced hallucinations
- 53% had suffered from a drug induced psychosis and paranoid delusions

Trauma

Youth often become homeless as a result of fleeing violence and abuse at home. Unfortunately, once on the street, many youth continue to experience trauma, violence and exploitation. Homeless street-involved youth experience physical and sexual violence at rates much higher than youth in the general population. The figures throughout this section refer to the total 100 youth sampled.

29% of survey respondents reported being physically or sexually assaulted in the past six months. Only 34% of those who had been assaulted received any medical support or counselling.

“Some people are scared, they don’t want people to know they were vulnerable, they let someone take advantage of them without fighting back, they don’t want to feel like they’re are weak... so they don’t talk about it.”

As well, many vulnerable homeless youth experience trauma and abuse in the form of sexual exploitation at the hands of older adults and from their peers. For youth struggling to survive on the streets,

exploitation is often in the form of being asked to exchange sex for basic needs, such as food, shelter and clothing; as well as for money or protection. 13% of survey respondents had been living with a client sex partner¹⁹ during the past 6 months, 5% in the past 7 days.

Stress

Many of the focus group participants expressed high levels of stress and dissatisfaction with their lives. Loneliness, hopelessness, fear, loss, trauma and stress were frequent themes in the focus group discussions. 86% of all survey respondents reported using drugs to cope with stress and 74% to escape. Yet drug use also had a negative impact on youth’s mental, emotional and physical health possibly reducing their ability to further cope with stress.

We asked youth to rate the amount of stress in their lives on most days. The following table displays youths’ appraisal of the amount of stress in their daily lives.

Self-Rate of Stress in Youth's Lives (n=100)

Not at all stressful	3%
A bit stressful	36%
Quite a bit stressful	32%
Extremely stressful	28%
Don't Know	1%

When asked about stressors in their lives, focus group participants spoke of numerous sources of stress, such as conflicts with the law, discrimination, stigma, poverty, struggles with interpersonal relationships, substance use issues, violence, trauma, homelessness, housing and the stressors that all young people face. The following explores

¹⁹ A client sex partner is someone who has given an individual money, drugs, goods or anything else in exchange for sex.

the various themes that youth identified in regards to sources of stress in their lives.

Meeting basic needs:

Focus group participants frequently identified their living conditions as the greatest source of stress. For those on the street, the constant battle of finding a place to sleep and finding refuge from the elements and dangers is very challenging. Those in shelters also had to contend with sharing space with many other youth and dealing with the rules of the shelter staff.

“Not knowing where you are going to sleep that night or where you’re going to get your meal...”

“[In shelters] there’s always some sort of drama going down.”

There was general agreement that having to leave the shelter where they were staying and having nowhere to go and nothing to do for the day was the very stressful for youth. This seemed to be connected to a sense of purposelessness and hopelessness:

“Being kicked out in the morning with nowhere to go, no motivation to do anything, no money, you don’t know where to start with yourself. What do I do with myself? You just feel like you’re this homeless teenager, this homeless youth, and you’re just like: ‘what do I do with myself? Where do I go from here?’”

Many focus group participants experienced stress when relying on programs and services in order to meet their daily needs as they are often offered at times and locations that do not work with the realities of their lives.

“Hours are a big thing. For drug addicted street youth, your thing is you wake up at twelve and then you are out ‘til twelve so nine to five isn’t always the best hours necessarily for people like us.”

For those in housing, they face many pressures to maintain their homes, including paying the bills, dealing with addiction issues and recovering from the experience of homelessness.

“The stress to maintain [housing] can push you back to doing drugs.”

The stress of making money is another significant source of stress for youth. Inconsistent income and the stigma associated with their source of income weighed heavily on the youth. Youth often struggled with making what money they do have last through the month.

“I was a panner [panhandler], some days I’d make a couple hundred bucks a day, some days only twenty. That’s not going to do it.”



Interpersonal relationships:

Many of the focus group participants characterized their relationships with their peers, friends, and families as being very stressful at times. Loss of loved ones, fractured relationships, experiences of abuse and trauma were common amongst survey and focus group participants. Some spoke of having their children taken away from them and placed in care. Others described the trauma of being sexually abused. Many also expressed feelings of extreme loneliness and difficulty in trusting anyone.

“Loss of friends... people you care about will leave you. They’ll walk away – especially if you slip more than once.”

“Not having someone that’s there for me.”

Establishing trusting relationships with workers was also cited as a source of stress and anxiety.

“When you go to a place, you always speak to different people...”

“You can’t really talk to someone you trust because your afraid they’ll judge you but at the same time you don’t really want to talk to someone you don’t know because you’re afraid they’re also going to judge you.”

Youth spoke of the challenge of making a change once engaged with the culture of street-youth.

“There’s a lot of stress to try and change your life. No matter what I did I try to avoid them, you can’t avoid them... I had to cut everybody off, even my best friend... You talk to one of them and they are all there and that’s a lot of stress.”

Substance use Issues:

Focus group participants described pressures from their communities to use certain drugs or methods. As well, addiction issues contributed to their stress levels.

“Making something of your life while your busy doing all your drugs and you’re stressed out ‘cause you’re not doing anything with yourself”

Being young:

Regardless on ones’ housing status, there are certain stressors that often come with being young. Focus group participants spoke of hormones, concerns regarding body image, dealing with parents, family, and school as sources of stress.

“Stressed out about school, it could be anything...”

“... not being able to fit in.”

“Peer pressure... That’s big.”

“I did it [drugs] for weight loss.”

WHERE YOUTH GET THEIR PRIMARY HEALTH CARE

The following table outlines where survey respondents received health care in the last six months. Multiple responses were permitted.

Sources of Health Care used by Respondents - Past 6 months	%
Emergency department	57%
Community Health Centre (i.e. Shout Clinic)	55%
Services at shelters, drop-ins, health bus	53%
Walk-in clinic	45%
Doctors office	27%
Hospital outpatient department	17%
Mental Health Facility (i.e. CAMH)	16%
Aboriginal health centre	9%
Alternative health centre	8%
Methadone clinic/provider	12%
Counsellor/therapist	24%
Psychiatrist	23%
Dentist	24%
Traditional healer	8%
Chiropodist (foot doctor)	8%

When asked about barriers to primary health care services, 64% of all survey participants reported experiencing various types of barriers and 36% reported experiencing no barriers. For more details, refer to the barriers section of this report.

Focus group participants made the following comments in regards to their experiences accessing health care services.

“[SHOUT] has got to be the best place ‘cause you offer everything here... here you get to see a real doctor. They need to take it more seriously at other places. Like here [Shout Clinic] you guys will go out on a limb for every client.”

“[There needs to be] more places like Shout Clinic... where you don’t necessarily have to go in with all these pieces of ID... they’re going to take you either way.”

“Sometimes your only hope is to check yourself into the hospital, but people don’t want to do that.”

and/or homelessness. Youth spoke highly of places where they had been treated with compassion, respect, discretion and dignity.

“... They make it safer for you.”

WHERE YOUTH GET THEIR MENTAL HEALTH CARE

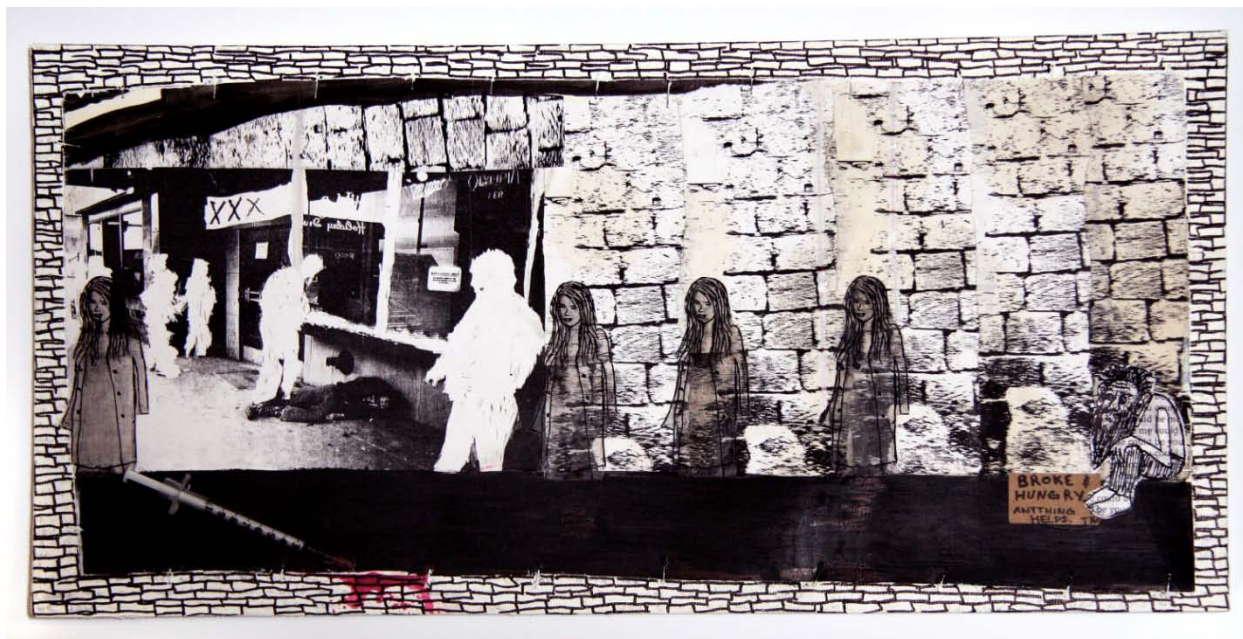
Despite the high rates of mental health diagnoses and concerns reported by survey respondents, there was low use of traditional mental health and counselling services. 16% had accessed mental health care at the Centre for Addiction & Mental Health (CAMH); 23% had seen a psychiatrist; and 24% had seen a counsellor or therapist in the past 6 months.

Focus group participants reported receiving support from service providers at community agencies, from outreach services, community health centres, needle exchange programs, drop-in centres and from shelter staff. In addition, youth may also be accessing other types of health services and providers that are not specific to mental health such as emergency rooms, community health centres, health professionals at shelters and drop-ins, and alternative health providers.

The participants pointed out a range of positive and negative experiences with service providers. Some youth felt that providers were more interested in their pay-cheques than helping youth. Others felt judged by workers and were unsure if they could trust them. Among survey and focus group participants there was unanimous preference for providers who had lived experience of drug use

DEPENDENCY AND ADDICTION

"The rush is there and your body wants it."



Artwork by L.P.

47% of survey respondents reported that in the past six months they had tried to cut down or quit their drug of choice but found that they were not able to. Focus group participants spoke of the overwhelming experience of addiction. Many of the focus group participants named addiction as a major source of stress in their lives. They said that once in the throes of addiction, consideration of risks came secondary to getting high.

"People do anything for their drugs."

Focus group participants acknowledged that their substance use has come with many costs: loss of friends and family, loss of their children, illnesses and infections, imprisonment, exploitation and violence, hunger, homelessness, as well as physical and mental health problems. Amongst participants there is a feeling that there is no end in sight.

"I wanted to quit, but growing up and not being anything... you don't think you can do it 'cause you've been beaten down..."

Accessing Supports and Services

When asked about their use of services in the past six months in order to cut down or quit using substances, 37% of survey respondents said they were not interested in cutting down or quitting; 21% had not accessed any services. The remainder of survey respondents had accessed the following services in order to cut down and/or quit using substances (multiple responses were permitted):

- 12% had accessed a detoxification centre
- 13% counselling
- 13% harm reduction counselling
- 12% methadone clinic/doctor
- 9% mental health facility (i.e. CAMH)
- 9% drug-free counselling
- 6% twelve step program
- 5% residential treatment program

In addition, youth also accessed emergency medical services, acupuncture and traditional healers. A few of the youth stated that they tried to quit on their own, going "cold turkey" or relying on self-help and/or the support of family and friends.

SEXUAL ACTIVITY AND USE OF LATEX BARRIERS

For a variety of reasons many people find it challenging to always practice safer sex. We asked survey respondents about their use of condoms and other types of latex barriers (i.e. dental dams, gloves, etc.) in the past six months and found that it was fairly low. Only 13% of respondents reported that they always used a condom or other type of latex barrier. When asked about why they didn't always using a latex barrier, 29% said that they were unable to get a condom or a dental dam when they needed one.

In addition to access issues, survey respondents cited many reasons for not using a condom or other latex barrier. In general, youth placed a high value on their social networks in regards to determining the level of risks they are exposed to and what protective measures they may need to take. Survey respondents spoke about the length and nature of their relationship as an important factor when deciding whether or not to use latex barriers with their sexual partners. For instance, if their relationship was monogamous they would choose to not use protection. As well, many relied on their partners being honest regarding being tested for sexually transmitted infections, using condoms when engaging in sex work, and whether or not they had previous sexual experiences.

The desire for increased intimacy and pleasure was also a key factor in their decision process. Youth commented on the importance of skin on skin

contact in order to gain intimacy and pleasure. For many youth, the use of latex barriers negatively impacted on their ability to feel pleasure, as well as maintain an erection.

The decision to use or not use latex barriers was also influenced by how important safer sex practices were to their sexual partners. If their partner didn't insist on using a latex barrier then they weren't used. In addition, youth spoke of monetary incentives to not using condoms when engaging in sex work such as sex clients offering to pay more. As well, lack of money played a role for youth as they could not afford to purchase condoms. This was especially true for those that had latex allergies, as non-latex condoms are extremely expensive and are generally not available for free at community agencies.

The type of sexual activity and whether or not youth were expecting to have sex also placed a role in their use of latex barriers. Some youth reported only using condoms for intercourse and not for oral sex. Many youth talked about getting caught up in the moment or being too high or intoxicated and as a result they engaged in unprotective sex activities.

Lack of knowledge or concern also influenced youth's choices, such as not caring or knowing about sexual health risks; and lack of concern for unplanned pregnancies. For some youth, not using condoms was a conscious choice as they were either trying to get pregnant or thought that they couldn't get pregnant.

When asked to rate their knowledge of safer sex practices, 52% of the 100 survey respondents rated their knowledge as excellent; 24% as good, 14% as fair; 6% as poor; and 4% didn't answer the question

The following tables display the frequency of condom use for various types of sexual activities. They are divided into the following four categories: male (identified) with female partners, male (identified) with male partners, female (identified)

respondents with male sex partners and female (identified) with female partners.

Frequency of latex barrier and/or condom use was measure in the following manner: Never equals never; occasionally/sometimes equals ¼ to ½ of the time; usually equals ¾ of the time; and always equals all of the time.

As the tables show, there was very little use of latex barriers among survey respondents. Though there was greater use among men who have sex with other men then there was among men whose sex partners were female, especially in regards to penetrative and oral sex. For women, there was very little use of latex barriers for anal and oral sex regardless of the gender identity of their partner(s).

Number of men with male sex partners and frequency of latex barrier and/or condom use (n=24)				
	Vaginal (n=0)	Anal (n=19)	Oral (n=22)	Fisting (n=3)
Never	N/A	2	7	1
Occasionally/Sometimes	N/A	6	5	0
Usually	N/A	3	2	0
Always	N/A	8	8	2

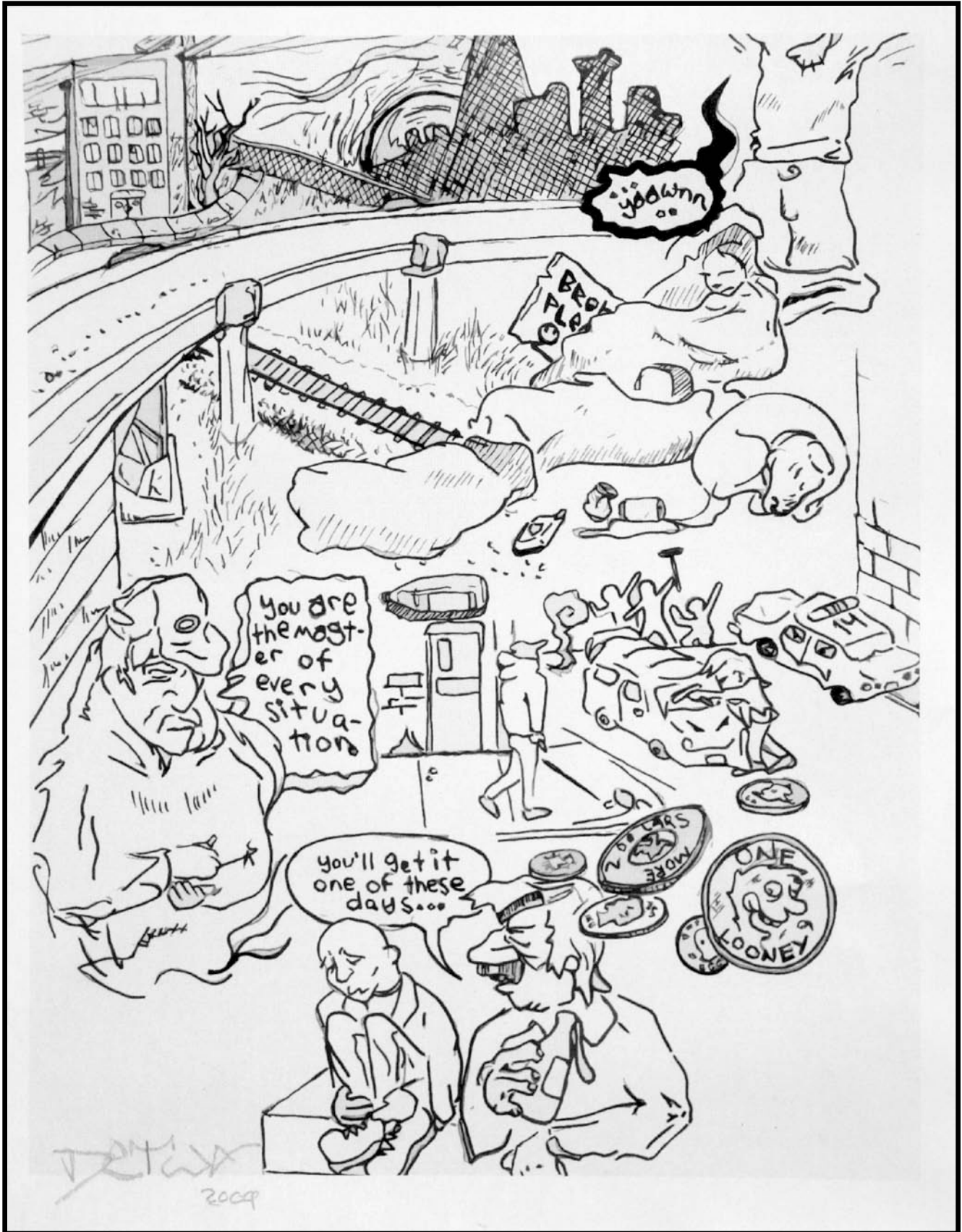
Number of men with female sex partners and frequency of latex barrier and/or condom use (n=59)				
	Vaginal (n=56)	Anal (n=19)	Oral (n=47)	Fisting (n=2)
Never	24	9	38	2
Occasionally/Sometimes	9	4	3	0
Usually	5	2	0	0
Always	18	4	6	0

Number of women with male sex partners and frequency of latex barrier and/or condom use (n=20)

	Vaginal (n=20)	Anal (n=4)	Oral (n=14)	Fisting (n=0)
Never	5	3	8	0
Occasionally/Sometimes	4	0	4	0
Usually	5	1	1	0
Always	6	0	1	0

Number of women with female sex partners and frequency of latex barrier and/or condom use (n=5)

	Vaginal (n=2)	Anal (n=0)	Oral (n=4)	Fisting (n=2)
Never	2	0	3	2
Always	0	0	1	0



Art work by Timm Preczewski

BARRIERS TO HARM REDUCTION, HEALTH CARE & COMMUNITY SERVICES



Survey respondents and focus group participants (from here on referred to as youth) were asked questions regarding barriers they experienced in obtaining services and supports. Certain barriers for multiple types of services, such as housing, employment, recreation, and education, as well as harm reduction, drug treatment, health care and counselling services were repeatedly identified.

The barriers youth identified relate to external factors such as policies and structures and internal cognitive factors such as attitudes and level of knowledge. In addition, some barriers are extremely complex and multi-dimensional such as those relating to homelessness, instability and fear of police, which intersect with all of the above categories.

The barriers reflected here are restricted to those brought up by youth who participated in this study. In addition, some of the barriers are given more weight than others.

Policy Barriers:

1. Lack of funding and support for harm reduction
2. Restrictive eligibility criteria

Structural Barriers:

1. Limited and inconvenient hours of operation
2. Limited and inconvenient locations of service delivery
3. Lack of transportation resources
4. Waiting times and waiting lists
5. Lack of program options and the power to choose
6. No health card or health care coverage

Attitudinal Barriers:

1. Social stigma and discrimination
2. Social networks
3. Staffing and interpersonal relationships

Knowledge Barriers:

1. Lack of knowledge of services and support
2. Lack of knowledge and concern for risks

Complex and Multi-Dimensional Barriers:

1. Homelessness and instability
2. Fear of police

POLICY BARRIERS:

1. Lack of funding and support for harm reduction:

“It’s probably very looked down upon by the government if you’re handing out harm reduction needle kits and crack kits to people under 16 [years old].”

There are conflicting messages in regards to government support for harm reduction services and approaches. For example, in 2005 the City of Toronto adopted a four-pillar approach to substance use (prevention, harm reduction, treatment and enforcement) but the Canadian federal government does not include harm reduction in its drug strategy. Conflicting messages and approaches also exist within community agencies serving homeless street-involved youth. Youth voiced awareness of the unevenness within the different levels of government and community agencies in regards to their approach to substance use issues and the provision of harm reduction services, supports and resources. They expressed concern that this affects their access to needed programs, services and resources and their vulnerability to conflict with the police and other service providers. When discussing the lack of harm reduction distribution programs for youth, one participant said this:

“Maybe agencies for youth don’t realize that us young people have such bad drug problems as the adults do.”

A lack of understanding and consistent support for harm reduction is a major factor in regards to agencies and staff accessing sufficient and secure, on-going funding and their ability to develop programs that truly meet the needs of street-involved youth. Insufficient funding and funding requirements may dictate the policies, eligibility criteria, ratio of staff-to-clients, hours and locations of services and types of programs and resources offered. Youth talked about the impact that funding

cuts were having on them in regards to reductions in services offered to them and loss of staff who they had built long term relationships with.

“I do not think there are enough resources to help everybody out... just like there’s never enough money if you have a habit.”

“They need to stop cutting you guys funding.”

2. Restrictive eligibility criteria:

Many agencies and most treatment centres have a lengthy intake process and requirements for eligibility that youth have difficulty meeting. Requirements such as being within a certain age bracket, not being under the influence, going through an intake interview, having a professional referral, and ability to be contacted by telephone or by mail are for many youth insurmountable obstacles in accessing services and supports.

“There’s a lot of red tape to get into a treatment centre: orientation, waiting list, appointment here, appointment there, it’s too many walls.”

Policies which require youth to abstain from being intoxicated or high while using their services restrict their access to needed services and supports as well contribute to youth’s fearfulness in respect to revealing to staff that they are using drugs. Fear of being judged or penalized by workers was a consistent concern for youth. Some youth stated that they would sleep rough (i.e. on the street) instead of returning to a shelter if they were using.

“I know at the shelter I’m staying at, I couldn’t admit to them that I was going to a meeting about my crack use because they would discharge me for admitting I use anything.”

Accesses to health care services are also impacted by eligibility restrictions. Youth who are from out of province are not eligible for provincial health care programs until they have been a resident of Ontario

for three months. Policies regarding health care coverage are especially hard for youth who move from province to province and have lost their original health card.

Most youth serving agencies are geared towards people 16 to under 25 years of age. For those youth who have developed trusting connections to youth-specific agencies, transitioning into the adult system can be very difficult, confusing and sometimes, quite traumatic. A lack of trust, support and service coordination can lead to youth becoming lost in the system upon leaving the youth sector. Often youth feel that they are not ready for the adult system and that the adult system does not have programs to meet their needs. Many youth are just starting to gain stability and address important issues, such as trauma, as they are getting older and are on the cusp of transitioning out of the youth sector. Youth frequently fall into a mental health “service gap” when they age out of care, resulting in termination of mental health and supportive services. Gains made while working closely with a particular agency may be lost when the connection is abruptly severed. These factors as well as separation anxiety and the stress associated with aging out of the youth system places these youth at additional risk for negative outcomes including imprisonment, decompensation, hospitalization, and homelessness.

“I’ll be twenty-five this year.... It’s getting out of the category and there’s hardly anywhere out there for twenty-five and up.”

STRUCTURAL BARRIERS:

1. Limited and inconvenient hours of operation:

Many youth find that they do not have access to services, support and resources that they need when they need it – at night and on the weekends. Youth felt that they have the least resources and are most vulnerable and at risk during these times. In general, services operate Monday to Friday, nine a.m. to five p.m. Youth agreed that these hours are not

amenable to their needs and does not reflect the realities of their lives. This is extremely true of harm reduction services.

“Hours are a big thing. For drug addicted street youth, your thing is you wake up at twelve and then you are out ‘til twelve so nine to five isn’t always the best hours necessarily for people like us.”

“Needle exchanges and safe kit places [safer crack kit distribution sites] might close, but dope dealers are available 24 hours a day, seven days a week.”

In addition, having to make appointments and fit into business hours in order to access primary health care providers (psychiatrist, counsellors, dentist, specialist, etc) and drug treatment services is also a struggle for most youth. Given the instability and other demands in their lives, youth find it very difficult to keep appointments; as well as to cope on their own in-between appointments.

“I find I make appointments with counsellors but they always want me to show up in the morning. A lot of drug users can’t do that. Counselling would help, and if it was later in the day.”

“Cause it’s like you’ll have problems and come in to talk about it but once you walk out no one’s there to help you.”

2. Limited and inconvenient locations of service delivery:

Location was repeatedly named as a barrier to accessing services, supports and resources as they are not always located where youth are living, hanging out, and using drugs. Youth stated that most services that are geared towards street-involved youth are located in the downtown core despite the fact that there are street-involved youth throughout the Greater Toronto Area (GTA). For youth who live or hang out in other parts of the city, location of

service delivery is often a barrier to practicing harm reduction as mobile and outreach programs are not extensive enough in their reach and youth often do not have the transportation resources to get there.

“There’s a lot downtown and not a lot on the outskirts of the city.”

“No one comes out to the east end where I live. They only come out one day a week and the rest of the days you’re screwed.”

When asked why youth sometimes share drug use equipment (e.g. syringes, pipes) or don’t access harm reduction programs, youth named a lack of a near by on-site or mobile needle exchange and/or harm reduction distribution program as one of the contributing factors. For youth who are housed, they may be more readily able to store supplies; however their exposure to outreach workers and proximity to agencies and services may be reduced depending on the location of their housing.

“If there’s no place for them to get clean needles and stuff like that, nine times out of ten they are going to use what they have.”

3. Lack of transportation resources:

Insufficient income and access to transportation resources is a constant barrier for youth trying to access harm reduction, health care and social service programs; as well as search for employment and housing. Youth’s small and erratic sources of income make paying for transit very difficult. Those staying at shelters may receive only one token a day which is not enough to get them to programs and services, housing and doctors appointments. On a daily basis, transportation barriers place youth in a position in which they are forced to weigh out the importance and urgency of competing needs. 17% of survey respondents couldn’t access health care due to a lack of transportation (in the past six months). Youth voiced their frustration at not being able access services or take advantage of programs in which

they were interested because they did not have a way to get there.

“We only get one token a day. How are we supposed to go look for an apartment and everything else when you only get one token?”

“The nearest harm reduction site is at least a streetcar ride a way. There’s nothing within walking distance to get a crack pipe.”

4. Waiting times and waiting lists:

15% of survey respondents reported waiting times to see health care professionals were too long and posed a barrier to medical attention. Being in a waiting room in a professional setting may be very distressing for some homeless and street-involved youth. They may be struggling with addiction and mental health issues as well as perceiving negative attitudes from others in the environment.

A common barrier to accessing mental health, counselling and drug treatment care is long waiting lists. There was strong agreement among youth that more timely services are needed and that waiting lists are a big problem. Youth feel frustrated at not being able to receive help when they need it.

“I went to detox before when I was pregnant with my first one... They told me I have a year and a half to two years on the waiting list. I’m like, ‘Um, hello?!’ The only one that was available was out of the city... they sent me all the way out to Ottawa for one away from my family and everything.”

“Say you need to see a psychiatrist, they won’t give you an appointment for a month and a half. The problem is now.”

“Sometimes your only hope [to see a psychiatrist] is to check yourself into the hospital but people don’t want to do that.”

5. Lack of program options and the power to choose:

Whether youth were discussing harm reduction, mental health, counselling or drug treatment programming, youth described a limited range of services, supports and program models being offered and noted the diversity of needs within the street-involved youth population. For example, almost all agencies lack child care facilities; for youth who are single parents, childcare issues often prevent them from accessing services, programs and community events.

“When youth have kids and everything... when you are going to the event what are you suppose to do with your children?”

A major criticism of harm reduction programs in Toronto is that they do not offer the type or amount of drug use equipment, such as methamphetamine pipes, snorting kits or drug testing kits needed for the patterns of drug use or the realities of street-involved youth.

“You guys have nothing for meth users so you’re not really doing anything ‘cause most of the youth in downtown are meth users.”

Along with supplies issues, youth want a wider range of harm reduction programs available to them, such as safer injection and consumption sites. Youth discussed the increased risks that they face such as using in unsafe locales, sharing and reusing drug use equipment, overdoses, crime and violence, social isolation, and conflicts with police as a result of not having safe places to use drugs. As well, many youth stated that the time they spent on finding a place to use drugs could be put to better use.

“Everything comes down to having no safe place to do drugs or buy drugs. You’re out on the street.”

For most youth, the first step in addressing drug dependency issues is to first work on reducing their drug use rather than eliminating substances altogether. Youth described a lack of options for them and having to accept going to abstinence programs that did not reflect their stage of readiness or their desired approach to substance use.

“Who wants to go to a group about not using crack when you’re all fucked up on crack?”

“I tried to go somewhere ‘cause I wanted to stop using drugs and because I’m in methadone it’s hard for me to stop, they don’t believe I really want to.”

In addition, youth felt that there are not enough options for residential or outpatient drug treatment programs. They described the positive and negative aspects of each type of program and concluded that for either program, there is not currently enough support to help individuals maintain their personal goals in regards to substance use issues outside of the programs. For some, entering residential treatment meant giving up their housing, a shelter bed, or a job.

“Some people can’t up and leave their situation, their place. They have people staying with them or they have animals...”

“Inpatient [treatment programs] often send you right out. If you can’t do it as an outpatient then you’re going to be right back to where you started.”

“I was offered inpatient but I had to do outpatient for nine weeks. I don’t want to do that. If I’m going once a week, the other six days I’m doing crack.”

Survey respondents and focus group participants said that many of the existing harm reduction programs as well as drug treatment programs are not geared towards youth and that they have

difficulty fitting into adult services. For example, in Toronto there are only four youth agencies which operate a needle exchange program. As well, there are no youth designated detoxification beds in existing detoxification centres (i.e. beds reserved for youth), nor are there any youth-only detoxification centres.

“Most youth don’t go to them because it’s not in their category. They’re more older people and everybody... when you go into detox its mostly older people in them.”

6. No health card or health care coverage:

29% of survey respondents stated that having no health card was a barrier to accessing health care services. Many homeless street-involved youth find it difficult to replace and hold on to cards due to theft and loss. One youth noted that it took them over a year to get their identification replaced. Often youth rely on hospitals for their health care, yet many are refused service at a hospital because they don’t have a health card. In addition, many youth are released from a corrections facility without medication or the means to get medication (drug card) and their ID (if they had any).

“Being homeless and going through all this drug things and what not you tend to lose your ID and your OHIP card... so you’re not able to get the resources ‘cause you don’t have your card.”

Youth receiving social assistance are given a monthly drug card to pay for medication but these too frequently get lost. Some youth may not be aware of their right to drug benefits. Others may be prescribed medications that are not covered by the government drug benefit program.

“Some can’t afford medication they need... some pills cost up to four hundred dollars. What youth on the street has that?”

Access to dental care is hampered by the fact that many dental clinics won’t accept patients on social assistance. As well, dental coverage is limited to emergencies and does not cover preventive procedures (i.e. check-ups, teeth cleaning, etc). Without sufficient coverage, many youth go without receiving dental health care, despite greater vulnerability to dental problems related to their substance use and living situations.

“So many people have trouble with their teeth. Especially if they’re doing drugs. Like, how many people have you seen on the street who don’t have teeth? Because it costs you three, four, thousand dollars to get a fucking tooth.”

ATTITUDINAL BARRIERS

1. Social stigma and discrimination:

Youth face social stigma and discrimination from the public, workers, health care providers, peers, and family members. Stigma and discrimination block access to resources and services as well as negatively affecting one’s self-esteem and outlook for the future.

Fear of being “outed” as a drug user and negative attitudes towards street-involved youth who use drugs, may reduce their willingness to access harm reduction programs and supplies. Lack of access places youth at an increased risk for substance use related harms and exploitation due to reliance on individuals for harm reduction supplies and education, as well as use of inappropriate materials (i.e. homemade pipes).

“Some of them are scared to come out and say they are using. They are too scared to access them [harm reduction services].”

In addition, concerns about confidentiality result in some youth avoiding services that publicly advertise as being for homeless and street-involved youth, people who use drugs and/or sex workers.

The fear of being judged or labelled with a mental health diagnosis prevents many youth from acknowledging mental health issues and trauma, and from getting professional help. For men, it's especially difficult for them to reveal experiences of abuse because of the way that they have been brought up and social norms about men and sex.

“They are embarrassed that they could have a mental health problem. They don't want people to see them going into CAMH or whatever.”

“There should be more info telling guys its okay to tell people they were sexually assaulted or raped... But how people are grown up is guys don't talk about that shit.”

Negative experiences, a lack of trust and poor quality of care relating to social stigma and discrimination within the health care sector create barriers to youth accessing health care services. Many street-involved youth fear disclosing their substance use, lack of housing or their involvement with sex work in order to avoid being judged, denied service and experiencing inferior treatment.

“It's kept me from getting proper treatment, just admitting what drugs I've done in the last week.”

“It's the medical community. There's really a stigma against people who use drug. So you don't always tell your psychiatrist that you use drugs... You can't always be truthful with your doctor.”

“You go to the hospital and they ask you what you've done and if you say you've done any drug, it's like they don't even do tests on you.”

For those who have thought about quitting or cutting back their drug use, the experience of trying to find supports and services may have reinforced their sense of hopelessness and invisibility due to social stigma and discrimination. Many youth have internalized negative stereotypes of youth and have very low self-esteem. Participants referred to lack of

caring for oneself as a barrier to accessing services and support.

“I wanted to quit but growing up and not being anything... you don't think you can do it 'cause you've been beaten down by words so much that it's like, what's the point, right?”

2. Social networks:

Youth social networks are often a source of support and can contribute to one's social capital. But they also have the power to act as a barrier to accessing harm reduction programs, mental health and counselling supports and services to assist youth in addressing drug dependency issues.

“It's hard to get off of drugs when your buddy's sitting there puffing off that pipe.”

In addition, social networks can have both a positive and a negative influence on behaviour and choice. Youth discussed peer pressure, group membership, and group norms as influencing what drugs and what consumption methods are used. Some of the youth felt that they were more comfortable getting drug use equipment from friends and other people in the drug scene.

“You're going to go where drugs are familiar.”
“If you're homeless or street-involved then you only know other street-involved.”

Many youth spoke of a reluctance to tell anyone about sexual or physical abuse due to concerns about being viewed as a rat or as weak. Youth stated that they found it especially difficult to report an assault that occurred at the hands of a friend.

“I think it's 'cause some of the sexual assaults are happening from your closest friends. And it fucks with your mind and you don't want to get your friends in trouble.”

Youth may be reluctant to address a substance use issue if it is linked to their communities. Focus group participants described having to give up their best friends or move out of the province in order to avoid substances. It is especially difficult when there are not enough after-care programs and services for youth.

“... You go to detox, but when you come out if you’re hanging out with the same friends, that does it – you’re back around it again.”

3. Staffing and interpersonal relationships:

Youth’s perception and experiences of social stigma and discrimination at the hands of service providers (as outlined in this report) are barriers to building trust and therefore barriers to accessing a wide range of services, including harm reduction, health care and substance use and mental health counselling and treatment.

“I was talking to my worker for a long time and he didn’t seem to be helping me at all ‘cause I wanted to get into treatment and he said ‘Well, I’ll call these places.’ Next week he was like: ‘Oh, I wanted to be sure you were still interested before I call.’ He said this at least three times.”

“It’s hard to tell... ‘cause they are being paid right? Are they just pretending you and looking at you with disgust? You don’t know with workers. Some of them do care but some are just there for the money so they put up a front, right?”

“If I’m going somewhere to get help with something, I want someone who’s legitimately been through it. I don’t want to hear what you learned in a book.”

Many of the youth find it difficult to establish trust with staff that do not support harm reduction or do not have adequate training and skills. Youth find it especially hard and frustrating when they are not

able to have one consistent, long-term worker. They feel that this is very difficult to find because many of the services are short-term, crisis-oriented, have a “rotating cast” of support people and end when you are 25.

“... You don’t really want to talk to someone you don’t know because you’re afraid they’re also going to judge you.”

“You need assistance to find a program and help getting into it... I helped my one friend after she got raped and the police were all fine and happy to bring her somewhere and write a report but once her night was up, her twenty-four hour stay or whatever... out the door again!”

KNOWLEDGE BARRIERS:

1. Lack of knowledge of services and support:

Street-involved youth may not always be aware of what services are available and which ones may be most welcoming and understanding of the complex issues that they face. Youth cited that a lack of awareness of services and program options is a barrier to reducing/eliminating harms and risks relating to substance use (i.e. sharing and re-using drug use equipment), taking care of ones health and well-being, accessing services and advocating for their rights (i.e. access to drug benefits and dental care under social assistance programs).

“Give them options. If they don’t know it they can’t access it.”

“The more accessible it is, the more known that it is, the more that people will use it.”

Lack of understanding of services also impacts on youth’s comfort in accessing services, especially ones in which stigma is attached, such as mental health services. Many youth are concerned that they will lose their rights, have their freedom restricted, and be placed on psychiatric medications. One participant stated that they were afraid that medications would be forced on them as a way of calming them and fixing their problems. Others discussed being afraid of getting lost in the mental health system. Participants suggested that their lack of understanding of the mental health system is perpetuated by media depictions of padded rooms, straight jackets and drug-induced stupor.

“Maybe the person isn’t out reaching for help because they are scared of what the outcome will be.”

“People may not be educated about psychological assessment. They may think you get taken away, your rights taken away from you, put you on meds or in a padded room.”

2. Lack of knowledge and concern of risks:

While many youth were able to identify risks and some strategies for safer drug use, there continues to be considerable amount of misinformation that needs to be addressed. Survey respondent’s answers to questions relating to their level of knowledge and their drug use practices are evidence of this. 30% of survey participants described their knowledge of safer drug use practices as poor to fair. As well, 24% of survey respondents who smoke crack stated that they did not know it wasn’t safe to share pipes. In addition, there were also low rates of concern among survey respondents in regards to HIV/AIDS and Hepatitis C transmission. Youth’s desire to get high and their level of intoxication influences both their awareness and concern of possible drug related harms and risks. A lack of concern for one’s physical health may reflect a lack of awareness of risks resulting in failure to access preventative health care and harm reduction services. Lack of concern may also reflect poor self-esteem and a sense of hopelessness.

“I always shared my crack pipe ‘cause I thought I was safe... I thought I couldn’t get sick from a crack pipe and then I got Hep C.”

“If you want to get high, you’re going to use it regardless.”

COMPLEX AND MULTI-DIMENSIONAL BARRIERS

1. Instability:

There are many factors which play a role in the level of instability in youths lives such as homelessness, imprisonment, drug dependency and chaotic life styles to name a few. Instability significantly impacts an individual’s ability to practice harm reduction and self-care and access to services including housing, harm reduction, health care, mental health and counselling, drug treatment, and income, employment and recreation programs. As well, instability negatively impacts on ones ability to follow through on referrals and appointments.

“Cause I had no housing, I wasn’t up in time or whatever so I missed the appointment.”

“If I have some place to come home to all the time, then I can focus on the next step.”

For many youth a large portion of their energy and time is directed towards more immediate needs such as finding a place to sleep that night, making money, trying to figure out where to get their next meal and locating drugs, harm reduction equipment and a safe place to use rather than towards addressing more long term issues, such as housing.

For youth who are being released from a correctional facility, discharge planning is an important but often neglected step in regard to continuity of care and re-establishing stability in their lives.

Lack of stable and secure housing is a barrier to supports and services to help with quitting or reducing substance use. Homelessness preoccupies youth, preventing them from being able to address substance use issues. Many youth lack coping skills and are therefore reluctant to quit drugs as they play a major role in how they cope with homelessness. For others, entering residential treatment means giving up sources of stability such as housing, a shelter bed, or a job.

“On the weekends there is nothing to eat so you think: ‘Well, fuck’ and you’ll take a hit of whatever you can get your hands on. When Monday comes around, why are you going to get treatment?”

Positive or negative, change can also be a destabilizing factor for some youth who become housed. With housing come new responsibilities that many youth lack the skills to manage. A lack of proper support when transitioning into housing may put many youth at greater risk of increased social isolation, drug use and eviction.

“You just need help balancing it out. The stress to maintain [housing] can push you back to drugs.”

2. Fear of police:

For street-involved youth negative experiences and knowledge that police officers are not always on board with harm reduction principles are barriers to using harm reduction services, receiving support, education and referrals as well as having access to harm reduction materials in order to reduce risks/harms.

“It doesn’t help with agencies getting you clean user-friendly stuff and then police taking them and smashing them – even making you smash them. Like, how does that really make someone feel when you’re trying to be safe and a cop makes you smash your pipe, you know?”

“Maybe that’s the reason why youth use dirty needles and crack pipes – because they keep getting their clean ones taken away.”

In addition, fear of police is a barrier to youth seeking medical care and emotional support after a physical and/or sexual assault due to possible police involvement.

“It fucks with your mind and you don’t want to get your friends in trouble.”

“When the police beat me up there was nothing I could do about it... I just left it alone ‘cause I was afraid of them.”

CONCLUSION & RECOMMENDATIONS:

The aim of this report is to record and present the voices of street-involved youth who are engaging in some of the most risky types of drug use and practices, including many who have done so from an early age. They present a unique insider view of the barriers they face in the access to and implementation of safer drug use services, many of which they are denied by virtue of youth, homelessness and marginality. While many prior reports have been concerned with drug use and homelessness, this is the first to focus specifically on this extremely vulnerable sub-group of the youthful homeless population.

The recommendations made by youth in this report echo and build on many of those recommendations made in other recent reports addressing youth, homelessness, and substance use in Canada (*see Appendix 1*).

General Statements:

- Youth speak out about instability
- What youth want
 - Options and choices of programs and services
 - Responsive, comprehensive and flexible services
 - Friendly faces and friendly places
- Youth speak out about receiving respect and fair treatment
- Target social stigma
- Treatment instead of jail

Common Theme:

- Youth friendly, non-judgmental, flexible approach to program design, ideally delivered by people with lived experience of issues youth are experiencing, which are provided with others in accessible locations.

Youth Speak Out about instability:

Youth repeatedly identified instability as a major barrier to transforming their lives. Instability touches on all aspects of their lives: housing, relationships, physical and mental health, income, employment, access to treatment and health care, and of course safer drug use. Lack of consistency in each of these areas builds and adds to the overall precariousness of their existence. The ability to move forward and establish stability in any one area is hampered by the stress emanating from another. Since youth must often address immediate needs and find ways of coping with their current realities, the ability to look to their future, stay healthy, and achieve their goals and dreams is seriously compromised.

Youth Speak Out about what they want:

1. **Options and choices of programs and services that are relevant to youth:** For example youth-specific detoxification services; safe, affordable, appropriate housing options (youth, harm reduction, transitional, supportive housing options); educational materials that are of interest to youth; and programs that are geared towards the complex and diverse realities of street-involved youth.

2. **Responsive, comprehensive, and flexible services:** locations, hours, policies, and creative and innovative approaches to meeting youth needs (services available 24 hour a day/ seven days a week; safe injection/consumption sites; treatment instead of imprisonment; outreach; harm reduction housing; etc).
3. **Friendly faces and friendly spaces:** welcoming environments, peer workers, opportunities to build relationships, harm reduction philosophy.
 - View of substance use as a health issue, not a criminal issue
 - Adoption of a harm reduction approach
 - Elimination of social stigma
 - Provision of appropriate housing
 - Development of new and innovative approaches to providing support services
 - Provision of low-barrier access to comprehensive and flexible services
 - Establishment of safe injection/consumption sites
 - The importance of comprehensive and high-quality discharge plans

Youth Speak Out about receiving respect and fair treatment:

The recommendations offered by youth in this study emphasize the importance of protecting youth with accessible and appropriate harm reduction services, rather than punishing them for their drug use. Their voices add to those calling for a non-judgmental, public health and human rights oriented perspective to people, young or old, who use drugs. This must be the priority for future programs if the tide of disease, overdose and premature death is to be halted.

Target social stigma:

There is an urgent need to develop new initiatives that draw together youth, service providers, researchers, advocates, government officials, police and politicians to target social stigma. A variety of anti-stigma initiatives were suggested by youth in order to educate the public, the police, and health and social service professionals including:

- Using the media to disseminate greater understanding of the realities of street-involved youth
- Using professional development sessions (staff training and capacity building) to garner support for a harm a reduction approach towards youth, substance use, and homelessness
- Having people with lived experience speak to different social and professional groups (i.e. at schools, community agencies, health centres, police stations)
- Inviting members of different professions to come to a group for street-involved youth so that they can hear the voices of youth

Treatment instead of jail:

Instead of going to jail, youth want to be offered the option to go to treatment (for example, drug court diversion programs) when they are arrested for substance-related offences.

“More treatment programs instead of putting everyone who uses drugs in jail.” “If you get arrested for having possession of drugs, you shouldn’t be given you know, 60 days in jail – you should get sentenced to rehabilitation.”

FOR ALL SERVICE PROVIDERS & SECTORS

What's working:

Focus group and survey participants shared examples of positive experiences with services for street-involved youth. Services that are designed specifically for youth and those that employ peer workers were highly regarded by respondents and participants. Mobile and outreach services and those that have an open-door or drop-in (no appointment necessary) component are also greatly appreciated. Youth spoke very passionately about workers and professionals who treated them with respect and who understood the issues and realities that street-involved youth face. The key message relayed by the participants is that these aspects of service-provision and approaches to service delivery must be expanded and given more support.

Ideas for change:

- Services where youth are and when they need them
- Programs that fit youth
- Choices
- Friendly faces and friendly places
- Two tokens a day

1. Services where youth are and when they need them:

First and foremost, many participants agreed that all services should be available to street-involved youth twenty-four hours a day, seven days a week. In order to address Toronto's changing demographics and community needs, services need to be located in all areas of the Greater Toronto Area, not just in the down town core.

“Relocate...So they're all around the city so they are accessible.”

“More in the afternoon instead of mornings... 'cause if they do it later, like in the afternoon and everything, the person can try and find a way there.”

2. Programs that fit youth:

Youth recommend that programs be designed to fit their needs instead of them having to try to fit the needs of the agencies. Along with hours and locations that reflect their daily lives, youth's individual and immediate needs should be taken into account in regards to intake procedures, eligibility requirements, and waiting lists. In addition, when designing programs and services, agencies need to ensure that barriers related to poverty are address (i.e. lack of housing, child care, transportation and telephone, and food security and literacy issues, etc). Youth want greater support getting into programs and in transitioning from the youth to the adult sector. Youth also stated that they require long term, individual support that is responsive to the changing types and levels of support that is needed.

“More assistance with getting into programs.”

“[Programs] that you can get into really easily. Like people coming off the street and where they are more flexible like they know our issues and our lifestyle.”

“More services for those 25 and up.”

3. Choices:

Choices were identified as having great importance to youth: choices of group or individual counselling, high or low support, outreach or on-site services, day or evening, abstinence or harm reduction, supportive housing or independent housing, peer workers or non-peers, etc. Program options need to be relevant to the youth: reflective of what they are asking for and of their lifestyles. Youth stressed that a 'one size fits all' approach did not work for them as different youth have different levels of comfort in

accessing services and a range of needs that change over time.

4. Friendly faces and friendly places:

A welcoming environment with youth-oriented programs was identified as a key factor in making agencies more appealing to youth. Youth strongly recommend that agencies hire more peer workers and staff consisting of people with lived experience who understand the realities of street-involved youth. Confidentiality, discretion, and a positive image are also very important to the youth participants. Youth want harm reduction support groups and other types of community programs to be given names that don't 'out' participants as people who use substances, are homeless and/or engage in sex work.

“If I’m going somewhere, anything, to get help with something, I want someone who’s legitimately been through it. I don’t want to hear what you learned in a book.”

“Give it a different name and a different image. Like, say it’s the pizza party of the week.”

5. Two tokens a day:

Providing youth with adequate transportation fare to get to services, programs and appointments was frequently suggested. TTC tokens and other incentives (i.e. honoraria, meals, food vouchers, etc.) were strongly recommended to enable and encourage youth to attend programs, recreational activities as well as educational and community events.

“Every shelter should have two tokens for each person.”

“Token, five bucks and a meal. Sounds like a winner to me!”

“And free food? You’re good to go! You gotta block party happening!”

FOR HARM REDUCTION, PUBLIC HEALTH PROFESSIONALS & YOUTH

Recommendations to Improve Access to Harm Reduction Services

What’s working:

- Harm reduction approach
- Youth/peer workers especially with lived experience
- Kindness, respect and discretion
- Opportunities for involvement and inclusion in program design and delivery
- Materials that are “youth-friendly” – catchy visuals, everyday slang, use of personal pronouns, ones written by youth

90% of survey respondents think that harm reduction is an appropriate and useful approach to substance use issues. Youth spoke highly of interactions with peer-workers. Youth describe feeling more comfortable with workers with lived experience. As well, they appreciate workers who approach them with kindness, respect, and discretion.

“Harm reduction workers are nice and they understand.”

“The good thing about them is they make you... the drugs you use and everything... they make it safer for you.”

“Some places that if you go in and tell them that you don’t want other people to see what they’re giving to you, they’ll put it in a bag and give it to you off to the side.”

The youth who are able to access services really appreciate both the type of harm reduction supplies offered and the ability to access unlimited amounts.

“What’s really working well is that you guys pretty much give out unlimited amounts of stuff so you can stock up.”

Youth desire opportunities for involvement and inclusion in program design and delivery. Some of the youth shared positive experiences making kits, developing brochures and working with peer-supports.

Many of the youth described information and education materials that they found to be very relevant and helpful. In particular, they preferred materials that have catchy visuals, everyday slang, use of personal pronouns, and ones written by youth.

“I like the Sharp Shooters booklet... it’s just got definitions that we understand.”

“Shoot Safe, Fuck Clean. Before I didn’t know where the safe injection spots were. Now I know the green areas [safer injection areas] and stuff.”

“I like the date rape book. It has little stories in there and places you can call.”

The key message is that while these are all positive things that are currently happening, greater support for and adoption of an integrated harm reduction approach by all agencies is needed. Programs need to expand and build upon what is working. More programs, services, materials, and supplies need to be available in more places and for more hours of the day. In addition, agencies need to continue to develop and expand opportunities for youth engagement and involvement.

Ideas for change:

- Deliver services where and when youth need them
- Spread the word – better advertisement of services
- Provide supplies that youth need and will use

- Relevant program options that are appealing to youth
- Provide greater access to educational materials and resources
- A safe place to use – safe injection and consumption sites

1. Deliver services where and when youth need them:

Key locations for service delivery that youth recommend include shelters, drop-in centres, community health centres, hospitals, correctional facilities, on the street, where people use, buy and sell drugs (i.e. bars, bathhouses, parties, ‘shooting galleries’, ‘crack houses’, etc.), and “everywhere”.

Services need to be located downtown and outside of the downtown core. Youth pointed out that there are homeless and street-involved youth throughout the Greater Toronto Area and that location of services should reflect this reality.

“Have them in the west end, east end, north end... ‘cause obviously there’s street-involved youth in all Toronto.”

Youth want more options for how they can access supplies. A recommendation is to have all shelters and drop-in centres mandated to provide harm reduction supplies. Creative approaches were also recommended such as having vending machines similar to those that dispense condoms; and allowing head shops to provide harm reduction supplies (i.e. syringes kits, safer crack use kits, etc).

“Instead of having harm reduction shelters, all shelters should mandatory have kits and harm reduction workers no matter what the shelter is.”

“Put up vending machines at the local... where they know users are getting high.”

56% of survey respondents recommend that the hours of operation should be twenty-four hours a

day, seven days a week. Youth also suggested that services be available in the late evenings (12 a.m. to 2 a.m.) and on weekends.

“They need to stay out ‘til one or two in the morning... Weekends are when you guys need to put more effort into it.”

2. Spread the word:

Youth recommend increasing advertising of services and supports in places where youth frequent socially as well as use drugs such as in alleyways or in fast-food places. Advertising needs to be clear, direct, and positive, respecting the need for discretion and dignity. In addition, it needs to utilize creative mediums which engage youth (i.e. internet, events, peer ambassadors, etc).

“More awareness. Such as maybe a website on Facebook. Publishing what facilities you have. Everyone uses Facebook.”

“Advertisement that makes the street-involved youth feel safe instead of a big sign that says “prostitution.”

“Throw a concert!”

“Just get out there more. More awareness. Maybe even try to get some youth involved to spread the word.”

“Have a great big map that has 1, 2, 3, 4, 5, different places that you can access.”

3. Provide supplies that youth need and will use:

Youth want greater access (including larger quantities) of current available supplies such as syringes and other injection equipment (ties, filters, vitamin c, cookers), safer crack use kits, safer sex supplies and basic need items (i.e. drinking water, socks, emergency food, and hygiene supplies). In

addition, youth want access to supplies and equipment that are not currently available in Toronto. Specifically youth want access to rose/oil pipes (for smoking methamphetamine), snorting devices, tattoo kits and drug-testing kits (to check the quality of ecstasy and other party drugs). 74% of survey respondents felt that the provision of safer methamphetamine use kits is a high priority. 84% of respondents stated that they would use a safer snorting kit if it was offered.

“I was told that in certain places you can get stuff to test your ecstasy.... What’s in it. Why doesn’t Toronto have that?”

“If they give out crack pipes, what’s the difference with meth pipes?”

4. Provide program options that are appealing to youth:

Needle exchange, outreach and mobile services are examples of the wide range of services that youth support. 82% of survey respondents strongly support street outreach services and programs. The majority of youth strongly recommend an expansion of the scope of fixed site, outreach and mobile services to cover more areas of the city, more hours of the day and more days of the week. Youth also want outside biohazard (syringe) drop-off boxes.

“They should have more people going and looking where these kids are, trying to find out where these kids are and start handing out equipment.”

73% of survey respondents recommend that agencies design harm reduction programs for specific groups of people. Some of the groups that were suggested as potentially benefiting from specifically targeted programs include youth, people who inject drugs and/or use methamphetamine, crack and/or opioids, sex workers, and individuals who identify as LGBTTIQQ2S.

Peer workers and mentoring programs were also highly recommended. 83% of survey respondents indicated that having peer workers involved in harm reduction programs is of high importance. Street-involved youth feel more comfortable talking to someone who understands their experience. They also stated that messages have a greater impact when they come from someone with lived experience. Hearing how other people have managed in similar circumstances stimulates hope and motivation.

“Like, hire other youth that have been into certain situations and have went through it. The only way to get to the other youth and stuff is to have people who have been through things similar to them.”

Other programs youth identified as high priority include:

- Harm reduction support groups for people living with mental health issues, HIV/AIDS, and Hepatitis C
- Harm reduction counselling and crisis intervention
- Harm reduction based supportive housing, shelters and hostels for youth who use drugs
- Individual and political advocacy support

5. Provide greater access to educational materials and resources:

Many examples of relevant and youth-friendly educational materials and resources were given by the youth; however youth felt that these materials need to be much more accessible. Youth stated that a variety of modes of education and information dissemination is important because different people learn in different ways. 58% of survey respondents indicated a preference for getting safer drug use and safer sex practices information from written materials such as brochures and booklets. 73% stated that written materials was a primary source

for getting information. 57% stated that they prefer spoken or verbal information.

“Brochures can be helpful but that doesn’t work for everyone. Some people like the hands-on thing.”

Strong visuals and accessible language (i.e. slang and everyday language) was identified as important for written materials like pamphlets and brochures. Youth are particularly interested in materials designed by youth for youth. They recommend increase opportunities for youth to get involved in producing education and information materials.

“Call the youth who have gone through these programs and ask them to be part of it.”

“If you actually show videos of how people’s lives went from here to there, from point A to point C, it might just open people’s eyes.”

Survey respondents identified bad drug alert flyers and youth-specific workshops and brochures as important educational resources that they would like to see offered. Recommended workshops included those that address substance use; Hepatitis C prevention, self-care and treatment; overdose prevention; crack, methamphetamine and injection drug use; and safer sex and sexual health. They expressed an interest in learning practical information and strategies. Preference was also given to workshops led by peers.

In addition to harm reduction information, youth want greater access to education about their rights; as well as legal and advocacy resources available to youth.

“A phone number to call when you get arrested”

“I would think that agencies should tell the youth what their rights are if a cop comes up and starts harassing you... know how to react to a situation

that's coming upon them... how to cut it off so it doesn't escalate."

6. A safe place to use - safe injection and consumption sites:

67% of the survey respondents indicated that they would use a supervised injection and/or consumption site if one were available. This was echoed by focus group participants. Youth who did not recommend a safer injection and/or consumption site did so mainly for reasons relating to not wanting to be watched by staff and other users.

The primary reasons for using a safe injection and/or consumption site include:

- Overdoses would be prevented and/or treated (97% of survey respondents)
- They would be able to use in a private space (96% of survey respondents)
- They would have access to sterile and new drug use equipment (94% of survey respondents)
- They would be able to safely dispose of used drug equipment (91% of survey respondents)
- They would have access to health professionals and other types of support staff (82% of survey respondents)
- They would have access to referrals for services such as counselling, detox and treatment (87% of survey respondents)
- They would be safe from being seen by police (85% of survey respondents)
- They would be safe from crime and violence (90% of survey respondents)

"This has already been said, but a safe drug use site - that would be a miracle... would save a lot of lives."

FOR ADDICTION & HARM REDUCTION PROFESSIONALS

Recommendations to improve access to services to support youth quitting or cutting down substance use:

What's working:

Some of the youth discussed social support and access to recreational activities as critical to their efforts to reduce or quit their substance use. There was general agreement that youth are looking for support from people who have their own personal experience with issues faced by youth such as homelessness and drug use.

Ideas for change:

- Increase options (for treatment and youth specific programs)
- Easier access
- Peer-workers and people with lived experience

1. Increase options:

Youth recommend more youth-specific programs and treatment options. As well they would like to see a more creative approach taken towards service design and modes of service delivery. Most urgently, youth recommend youth-only detoxification centres or at minimum, youth-specific beds within the current system. They want to have options of residential or out-patient programs, and group or individual counselling. It is recommended that there be a range in program options that include abstinence as well as harm reduction

"Part of drug addiction is talking about it but instead of just sitting in the office, go out somewhere. Go to the park and have ice cream and talk about it."

“I think one-to-one counselling would work. Speaking to other drug users just makes me want to use more.”

After-care and continuity of care are services that were acknowledged as important. Supports for reducing or quitting substance use should take a holistic approach and look beyond the drug to address other factors such as housing, social networks, income, mental health, and trauma. Continuity of care would expand to include assisting youth in re-integrating into the community by securing housing, income, primary health care, and linking youth with employment, educational and recreational opportunities, etc. Youth also recommend expanding recreational programs and social activities as they are helpful to youth who are trying to quit or reduce their substance use.

“If you have enough people that care about you and are willing to go through what you’re going through while you’re on these drugs... it’s easier for you to change...”

“If you are taking them out of the situation and give them more things to do you’re helping them. ‘Cause you are getting their minds away from drugs.”

2. Easier access:

Reducing waiting time and increasing the flexibility of programs and services was determined to be very important. Youth-friendly intake procedures, self-referrals, informal assessments, drop-in services, and flexible hours would make treatment services more appealing to youth. It is also important to have more services and programs available to youth in Toronto so that they do not have to leave the city.

3. Peer-workers and people with lived experience:

Having peer workers and people with lived experience on staff at treatment services was again

voiced as being very important. Youth described feeling more comfortable talking about their use of substances and other issues with someone who has been through similar experiences themselves.

“Like mentors, people who have gone through those experiences but have been off of drugs speaking to youth that are trying to quit drugs.”

FOR MENTAL HEALTH PROFESSIONALS

Recommendations to Improve Access to Mental Health Care and Counselling Services

What’s working:

Focus group and survey participants value services that are provided in a non-judgmental and confidential manner and are responsive to their complex needs. Discretion, safety, awareness of issues, and respect are highly valued.

Ideas for change:

- Tackle social stigma and promote mental health services
- More responsive services
- Program options
- Positive relationships

1. Tackle social stigma and promote mental health services:

Youth identified social stigma and lack of understanding of the mental health system as barriers to accessing mental health services. Anti-stigma initiatives are recommended to decrease resistance to acknowledging mental health issues and increase willingness to get help.

“Make them feel they’re just like everybody else, just because they have a mental problem or a chemical imbalance in their brain doesn’t mean they are any less...”

“There should be more info telling guys its okay to tell people they were sexually assaulted or raped.”

Increased promotion of mental health services has been strongly recommended. In addition to raising awareness of what services are available and how to access them, it is also recommended to increase understanding of what to expect from the mental health system, how it works, and what rights individuals have when they access mental health services. Once again, preference has been stated for programs that respond to the unique needs of street-involved youth.

“It’s always education: more signs, more commercials. You don’t see any commercials anymore for mental health.”

2. More responsive services:

Waiting lists and the need for professional referrals are significant barriers to youth access to mental health services. They recommend an increase in outreach services and greater flexibility in the referral process. Mobile services and greater flexibility in hours and appointments are also recommended. Having mental health workers who are fully aware of the complex issues that street-involved youth face is essential. Again, there is strong preference stated by youth to work with mental health professionals who have lived experience.

“Have mental health people come to the outreach places not have people have to go to mental health institutions.”

“I think like, more help for mental health issues instead of having to wait so long.”

“I think maybe once a week or once a month you should go to every shelter and pick out every single kid in that place and have a 15 minute one-on-one with them.”

“Sooner response times... The problem is now.”

3. Program options:

Many of the youth participants called for an increase in life skills and stress management programs. They also called for options to participate in either individual or group counselling.

“More information on stress management and how to deal with daily stress, daily problems... hands on program... Show people how to deal with a simple little stressful thing before it blows up in your face.”

“A calming session. Like talking to a psychiatrist only in a group.”

4. Positive relationships:

Mental health professionals and counsellors should have specialized knowledge and understanding of the realities of street-involved youth. Youth recommend having opportunities to establish an on-going working relationship with one worker so that a trusting rapport may be developed.

“Call and see if you are okay in between appointments.”

“Support workers that help you go through your trauma.”

“Let them know its okay to talk it out, that’s its okay to talk out what happened not to be afraid of speaking about what happened to you.”

FOR COMMUNITY HEALTH SERVICES

What's working:

Youth strongly recommend community health centres like SHOUT Clinic as well as outreach and satellite clinics.

"This [SHOUT] has to be the best place 'cause you offer everything here. Like you get to see a real doctor. They need to take it more seriously at other places. Like here you guys will go out on a limb for every client."

Ideas for change:

- No health care card necessary
- One stop shop
- Flexible hours and drop-in appointments
- Address discrimination by educating health professionals

1. No health care necessary:

Youth recommend eliminating the requirement of a health card to access health care services and increase access to ID clinics. It was also suggested that having nation-wide health care coverage is important for those who move between provinces. Another suggestion was to have a benefit plan for youth to cover costs of their medications and dental care.

"Canadian wide health service – not just provincial, all around, 'cause I'm a traveler."

"Some coverage plan for homeless youth."

2. One-stop-shop:

Youth strongly support agencies that are able to provide multiple services in one place. The idea of a "one-stop-shop" was very popular. It was suggested

that access to medical care, medications, supplies, I.D. clinics, dental care, counselling services, a place to sleep and get food, etc. all be available in one place. For example, it was recommended that doctors, nurses, mental health workers, and dentists be available in the shelter system.

"I think its gotta be a one-stop-shop. Everything's gotta be combined, even at a shelter. If someone's got ADD and bipolar and a drug addiction, they send you here for this and that... It's gotta be more accessible at the shelters, where you're at."

"More dental care. 'Cause so many people have trouble with their teeth. Especially if they're doing drugs."

3. Flexible hours and drop-in appointments:

Youth want health care services available to them when they need them and these times are often outside of regular clinic hours – especially weekends and evenings. Drop-in appointments are recommended because they provide opportunities for youth to engage with health care services when they need them.

"Something after four o'clock. Maybe some kind of night-time, once-a-week health place and open on Saturdays."

4. Address discrimination by educating health professionals:

In order for youth to feel comfortable accessing health care, it is recommended that health care professionals be educated to understand the realities of street-involved youth's lives in an effort to decrease social stigma. In addition, youth recommend that health care professionals receive harm reduction training in order to increase their capacity and competency to provide effective health care services. Youth want to know that they will be treated with respect and that their concerns will be

addressed diligently. Youth want to be treated as a whole person and in a holistic manner (i.e. not all health issues are due to drug use). Greater adoption of harm reduction approaches by health professionals is recommended. Health professionals have the opportunity to support youth in making choices that help reduce their exposure to risks.

FOR MUNICIPAL AND PROVINCIAL GOVERNMENTS

Ideas for Change:

- Secure government funding
- Increase stability – e.g. through an inter-Ministerial approach in order to address the different social determinants of health operating here

1. Secure government funding:

Linked up services and programs: Youth participants expressed frustration with barriers to multiple services such as housing, employment, recreation, and education, as well as harm reduction and health care services. Youth stressed that there must be much greater flexibility in the eligibility criteria and in the hours and locations of service delivery in order to increase their ability to access services and supports. Tackling stigma, nurturing trusting relationships and creating welcoming environments, providing resources and incentives, increased advertising and awareness of services, secure government funding, and increased organizational stability were recommended.

These recommendations apply to all services sectors (i.e. harm reduction, primary health care, drug treatment, housing and other social services).

Youth recognize that the scope of services is limited by funders' requirements and by lack of secure,

equitable and ongoing funding. They recommend that funding bodies provide agencies with the level of funding required to properly staff and manage existing as well as new programs and resources for youth.

"I know it's hard with the funding situation right now, but the more programs, the better..."

"They need to stop cutting you guys' funding."

2. Increase stability:

Youth identified stability as an essential ingredient to being able to access services. Secure housing, adequate and dependable income (including increases to OW and ODSP benefits), employment and recreation programs, trusting relationships with health care and service providers are all important pieces that need to be in place.

Housing is an important first step towards stability and positive change. Many youth felt that with the increased stability of having a safe and secure place to live, they would have more time to focus on other issues. Others felt that they would be more likely to make it to appointments if they had a regular place to stay and a routine established.

"Gotta focus on housing first and see what stems from there."

Continuity of care is crucial for increasing stability and uptake of services. Service providers who work together in collaboration can assist youth in maintaining access to services as they move through the system. For example, comprehensive discharge planning from the jail or detention centres or from treatment centres into the community; responsive housing support workers; flexibility and support for youth who are transitioning from the youth sector to the adult sector.

FOR THE POLICE

achieving these goals, as is involving them in evaluating the effectiveness of the new process.

Ideas for Change:

- Bringing police on board – e.g. working with the police, seek to create more education/training around harm reduction

1. Bringing police on board:

Positive experiences with police officers demonstrate the potential role of police as a resource and an ally to street-involved youth practicing harm reduction strategies. Police have the capacity to provide resources and referrals, steering youth towards harm reduction and health services instead of towards the criminal justice system.

Youth recommend training for police about working with street-involved youth and about harm reduction. Suggestions for improving interactions between youth and police included inviting police officers to come to groups to hear the experiences of youth and learn about their realities on the street. Other creative recommendations included having a harm reduction worker accompany police or even more preferable, having a harm reduction unit as part of Toronto Police Services.

“Bring the police officers to a session like this [focus group].”

Youth expressed great interest in having a meaningful complaint process for when they have experienced unfair, discriminatory, or abusive treatment from a police officer. Additionally, youth call for greater police accountability as well as more support from agencies about their rights and how to deal with harassment and violence from police.

Educating youth and service providers about the new independent police complaint process (the Independent Police Review Director) is paramount in

APPENDIX 1

Recent Canadian Reports on Youth, Homelessness and Substance Use – a summary of reports' recommendations reflect consensus with Youth Speak Out recommendations

We have included brief summaries of recommendations made by other recent Canadian reports on youth, homelessness and substance use to demonstrate the overlap and consensus on what youth want. The goal in providing this is to highlight common themes and recommendations so that all of the voices that have contributed to these reports are more clearly heard by service providers and policy makers.

1. **Ralf Juergens, and the Canadian HIV/AIDS Legal Network.** 2005. *"Nothing about Us Without Us."* Report available at: www.aidslaw.cpha.ca

This national report identifies HIV and HCV among people who use illegal drugs as a public health and human rights crisis. Its recommendations particularly stress the importance of involving people who use drugs in decisions about the services and programs aiming to improve and protect their health. This echoes our findings that homeless youth want to be, and are very capable of, being involved in decisions which affect their lives.

2. **City of Toronto. Toronto Drug Strategy.** 2005. Report available at: www.toronto.ca/health/drugstrategy/reportsandfactsheet.htm

The Toronto Drug Strategy's identified youth as one of the seven key themes that emerged from their public consultation process. They describe how youth use alcohol and other drugs for reasons similarly to those of adults, but also have additional reasons such as to show "independence and courage, to fit in with peers, and to satisfy curiosity" (TDS, 2005: 20). It also points out that the street-involved youth have higher rates of use with greater impacts than other youth

who are not street-involved. Many of the 68 recommendations made in the Toronto Drug Strategy affect youth. The following ones have been drawn out for their relevance to street-involved youth, though many other recommendations not addressed here will touch on their lives as well.

- **Funding:** secure ongoing funding for harm reduction programs (housing, employment, supplies, etc); for treatment options (residential, detoxification beds); and for community-based case management services for comprehensive support
- **Awareness:** anti-stigma initiatives; education and training about mental health and substance use for enforcement, health, mental health and social service providers; greater understanding of what services are needed and where
- **Justice:** develop alternatives to enforcement strategies and to prosecution (i.e. diversion programs); comprehensive release and follow-up care plans
- **Expansion of harm reduction service:** develop a local drug and drug use surveillance system (i.e. broad-based alerts); expand overdose prevention strategies; develop innovative harm reduction outreach strategies
- **Address poverty:** advocate for addictions to be recognized as a disability by the Ontario Disability Support Program (ODSP) and for an increase in minimum wage and social assistance to reflect costs of living

- **Address service barriers:** ensure that prevention, harm reduction and treatment services are available where people need them throughout the city and make sure this information is available to diverse populations
- **Promote opportunities for people who use drugs:** support peer programs and the development of a drug-user group
- **Supervised consumption sites:** conduct a needs assessment and feasibility study for supervised consumption sites in Toronto

3. Ontario Needle Exchange Coordinating Committee. 2006. Strike C, Leonard L, Millson M, Anstice S, Berkeley N, Medd E. *Ontario needle exchange programs: Best practice recommendations*. 2006. Report is available at: http://www.health.gov.on.ca/english/providers/pub/aids/reports/ontario_needle_exchange_programs_best_practices_report.pdf

This report contains 103 concrete recommendations for the operational, controversial, and practical challenges faced by needle exchange programs (NEPs).

4. Ontario Needle Exchange Coordinating Committee. 2009. Strike C, Watson TM, Hopkins S, Lavigne P, Young D, Shore R, Leonard L, Millson P. *Best Practices and Barriers: An Update for Ontario Needle Exchange Programs*. Report available at: <http://www.ohrdp.ca/wp-content/uploads/pdf/2009BPRupdate.pdf>

The goal of this report is to assess the extent to which the *Best Practice Recommendations* have been implemented, identify implementation barriers, and advance ones knowledge transfer skills to improve uptake. The report includes the following recommendations:

- Encourage the Ontario Ministry of Health and Long-Term Care to use the *Best Practice*

Recommendations as the foundation for the future development of policy and practice standards.

- Ensure that the *Best Practice Recommendations* (2006) and these findings are distributed to all NEPs and their satellite programs, and other interested organizations and jurisdictions
- Ensure that all Needle Exchange Programs (NEPs) distribute all injection-related equipment, distribute the types of equipment that are recommended, and distribute safer inhalation equipment
- Ensure in-service training to assist NEPs to develop agreements and conflict resolution protocols with local law enforcement
- Assist NEPs to identify and secure sustainable funding to increase the number of service models that are available
- Secure funding, develop, and disseminate *Best Practice Recommendations* for programmatic responses to the following: methamphetamine, Oxycontin™, safer injecting facilities, safer inhalation equipment, and prison-based NEPs
- Develop a partnership with the College of Physicians and Surgeons of Ontario to ensure that *Best Practice Recommendations* are developed for buprenorphine and heroin substitution programs

5. Raising the Roof (a Youthworks Initiative). 2009. *Youth Homelessness in Canada: The Road to Solutions*. Report available at: www.raisingtheroof.org/lrn-youth-index.cfm

This report identifies three areas of action (prevention, emergency response and transitions out of homelessness) and provides recommendations for strategies to address youth homelessness:

- **Prevention:** Address key triggers of youth homelessness through public education, anti-

stigma initiatives, etc. Address family-related issues and system reform (i.e. barriers to service access, child protection services, education, justice system, aboriginal youth)

- **Emergency response:** Address access to services; provide outreach services; address health mental health, addictions, and complex needs; housing / shelter; a harm reduction approach
- **Transitions out of homelessness:** Provide access to youth-focused transitional and supportive housing to help build stability; build community and social support; provide follow-up and long-term supports. Also recommend agencies coordinate support, evaluate programs, engage in research, and develop community-based and strategic responses

6. Street Health. 2007. *The Street Health Report*. Report available at: www.streethealth.ca/publications.htm

The Street Health Report (2007) provides recommendations for the areas of health care and treatment; harm reduction services; shelters and drop-ins; income; and housing. The Street Health Action Plan includes the following solutions:

- Address the poverty and inequality that underlie homelessness
- Improve access to affordable and appropriate housing
- Improve immediate living conditions for homeless people
- Improve access to health care and support for homeless people

Embedded in these solutions are recommendations that share goals with what youth want:

- Create new and expand existing services to be more comprehensive, multidisciplinary, and low-barrier
- Establish a safe consumption site
- Address poverty and provide appropriate housing
- Have services that operate from a harm reduction philosophy
- Educate and promote awareness of the needs of street-involved youth

7. McCreary Centre Society. 2008. *Improving the Odds: Next Steps Workshops with Marginalized and Street-involved Youth in B.C.* Report available at: www.mcs.bc.ca/rs_new.htm

In 2007, The McCreary Centre Society released their report: *Against the Odds: a profile of marginalized and street-involved youth in BC* (McCreary Centre Society, 2007). In 2007 and 2008, they held the Next Steps workshop series to provide opportunities for youth to discuss the results of the Against the Odds research, to make recommendations for change, and to plan projects for improving the health of youth in communities across BC. The following key points of action were voice by youth:

- Ensure all youth in government care know their rights
- Provide youth with more safe, clean and shelters and affordable housing; as well as 24-hour youth centres
- Provide more services and programs for youth in every community
- As most youth leave home at 13-14 there is a need to target support for younger youth
- Make more services for youth pet-friendly
- Provide more outreach and other trained workers to assist youth

- Provide more programs for youth turning 19 years of age
- Support youth to stay connected to school
- Improve access to primary health care
- Increase opportunities for involvement in sports and recreation activities to youth before and after they become street-involved
- Provide affordable prevention and treatment options for youth who are using or at risk of using drugs and alcohol. Improve the services offered to youth who need treatment for drugs and alcohol
- Increase youths' awareness and assertiveness around the need to wear a condom when engaging in sexual intercourse
- Develop more programs that raise awareness about sexual exploitation and provide services to youth who are being sexually exploited

8. **Gaetz, Stephen and O'Grady, Bill.** 2006. *The Missing Link: Discharge planning, Incarceration and Homelessness*. John Howard Society. Report available at: www.homelesshub.ca/Library/The-Missing-Link-Discharge-Planning-Incarceration-and-Homelessness-34835.aspx?search=missing+link&orgSearchString=the+missing+link

The research discussed in this report focused on the relationship between imprisonment, prisoner pre-entry, and homelessness. Recommendations that came out of this report that relate to those recommendations voiced by our survey and focus group participants include:

- The provision of high quality and appropriate discharge planning and transitional supports
- Adopt a policy that access to adequate housing becomes a priority in discharge planning

- All levels of government work together with the non-profit sector to develop supportive and transitional housing resources for inmates discharged from provincial institutions
- The Province of Ontario mandates that all prisoners have access to harm reduction programming, materials and supports

9. **Gaetz, Stephen, O'Grady, Bill and Justice for Children and Youth.** 2010. Update of the 2002 report *"Street Justice: Homeless Youth and Access to Justice."* Two reports will be available in 2010 at: www.jficy.org

Report 1: Youth Homelessness and Criminal Victimization

This report, which updates the research done as part of the 2002 JFCY needs assessment, looks at the criminal victimization of homeless youth. Preliminary analysis suggests that homeless youth are exponentially more likely to be victims of a whole range of crimes than are domiciled youth. More significantly, women and young teenagers (between 16-18) are much more likely to be victims of crime, including violent crime. This research will raise questions about the Canadian response to youth homelessness, and the need to shift the focus of public debates on street youth from 'perpetrators' of crime to 'victims' in need of protection.

Report 2: The Criminalization of Homelessness in Canada and its impact on Street Youth

This report explores the interactions between street youth and the justice system, and more particularly, with police and private security firms. Preliminary analysis identifies that most street youth regularly come into contact with police, not as victims of crime, but as potential perpetrators of crime. Such policing involves regular 'stop and searches', ticketing for a broad range of offences (including, but not limited to Safe Streets Act violations) and arrest. Private security firms also regularly engage street youth. Because street youth lack private space as a result of their homelessness, their activities (such as drinking in public or sleeping in parks) often

bring them into contact with law enforcement. Moreover, it will be argued that the degree of attention that street youth receive from law enforcement officials is a reflection of the degree to which the criminalization of homelessness is a central strategy of the Canadian response to homelessness.

10. Toronto Youth Cabinet. 2005. *Catch Us Before We Fall*. Toronto. Report available at <http://homelessness.samhsa.gov/Resource/QuickSearch.aspx?search=catch+us+before+we+fall>

Key recommendations from the Toronto Youth Cabinet's report include:

- Staff training and capacity building (including police and service providers)
- Support services:
 - Increase access to harm reduction shelters
 - Establish new and innovative approaches to obtain and retain stable housing; and to obtain and retain services like harm reduction, health care, legal, etc.
 - Establish policies and programs to identify youth who are charged/convicted and to divert them to the proper appropriate measures
- Affordable housing:
 - Eliminate policies and practices that prevent youth from accessing stable housing
 - Housing with support programs and with readily available supportive staff that interact with you on an individual basis

11. Safe Crack Use Coalition. 2002. *Toronto Crack Users Perspectives: Inside, Outside, Upside Down*. Report available at: [http://wellesleyinstitute.com/research/funded-](http://wellesleyinstitute.com/research/funded-research/enabling-grants/toronto-crack-users-perspectives-inside-outside-upside-down)

[research/enabling-grants/toronto-crack-users-perspectives-inside-outside-upside-down](http://wellesleyinstitute.com/research/funded-research/enabling-grants/toronto-crack-users-perspectives-inside-outside-upside-down)

The following recommendations from this study reflect those stated by Youth Speak Out participants:

- Substance use needs to be seen as a health issue, not a criminal issue
- Barriers to health care access must be addressed
- Address mental health issues without further stigmatizing individuals
- Advance and infuse harm reduction methods into best practices
- Safe consumption sites need to be developed
- Increase outreach and counselling services
- Address poverty and lack of housing
- Advocate for people who use substances and increase their role as a collective

12. Toronto Youth Street Stories. 2007-ongoing: www.tyss.org

This web-based story telling project showcases the poems, essays, and art produced by Toronto youth who attended author-led creative workshops at agencies for street-involved youth. This website was designed to empower youth, be an information resource, and help to counter stigma about lives on the streets. Much of the material refers to drug use experiences. The website also includes research reports from the Youth Pathways Project, which interviewed 150 homeless youth in 2005-2006, on themes of maltreatment, sexual minority status and pregnancy.

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Enabling Grants

The Wellesley Institute's Enabling Grants programs supports community agencies and providers to collaboratively pursue research on issues that urban communities identify as important. These may include identifying unmet needs, exploring or testing effective solutions to problems they experience, or increasing our understanding of the forces that shape people's health and the way these forces affect people's health. The Wellesley Institute's strategic focus is Health Equity, and we work in diverse collaborations and partnerships for social innovation, progressive social change, policy alternatives, and solutions to pressing issues of urban health and health equity.

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- Horizons for Youth



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45 Charles St. East,
Suite 101
Toronto, ON, Canada
M4Y 1S2

Tel 416.972.1010

www.wellesleyinstitute.com

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