The Substance of Harm Reduction: A Framework for Youth Supportive Recovery

By

Lewis Rhodes
BA, University of Victoria, 2013
BA, Simon Fraser University, 2016
BEd, Simon Fraser University, 2017

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We acknowledge and respect the Lək'ʷəŋən (Songhees and Xʷsepsəm/ Esquimalt) Peoples on whose territory the university stands, and the Lək'ʷəŋən and W̱ SÁNEĆ Peoples whose historical relationships with the land continue to this day.

Supervisory Committee

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Lewis Rhodes
(BA, University of Victoria, 2013)
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Supervisory Committee:

Dr. Shemine Gulamhusein,
Assistant Professor, School of Child and Youth Care

Dr. James Anglin,
Professor Emeritus, School of Child and Youth Care

Kacie Stirrett,
Manager, Threshold Supportive Recovery Program

Abstract

This master's research project develops the Harm Reduction Recovery for Youth (HRR-Y) framework, a structured practice framework integrating harm reduction and recovery-oriented care within a residential substance use program for youth aged 15 to 21 at Threshold Housing Society's Supportive Recovery Program (SRP). Using qualitative data from staff interviews and daily logs, the project translates frontline staff expertise into a six-tier framework spanning relational residential care, recovery programming, behavioural interventions, medication protocols, substance substitution, and supervised safer use. Each tier of interventions plays an important role in supporting residents to manage their substance use. Positioned within the context of British Columbia's ongoing toxic drug crisis and a contentious policy landscape, the framework advances youth substance use supports by combining harm reduction and recovery principles with therapeutic residential care. This framework could be further strengthened by incorporating youth voices in future research, additional iterative opportunities for staff-led refinement, and conducting outcome evaluations.

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Chapter One: Introduction

Youth substance use represents a pressing public health challenge in British Columbia, a province located on Canada's west coast with a diverse population of approximately 5.3 million people, encompassing urban centres, rural communities, and Indigenous territories. The province has been deeply affected by an ongoing toxic drug crisis, which has led to a sustained increase in overdose deaths since 2016, with more than 10,000 fatalities reported provincially during this period (BC Coroners Service, 2024). Over the past decade, BC has had the highest burden of overdose deaths per capita among other provinces, with Indigenous populations bearing a disproportionate burden of the harms related to substance use (Jongbloed, 2017; Public Health Agency of Canada, 2025; Truth and Reconciliation Commission of Canada, 2015; Urbanoski, 2017). Between 2019 and 2023, youth under the age of 19 comprised a notable portion of this toll, with 126 deaths reported as unregulated drug toxicity deaths, averaging approximately 25 deaths annually. Unregulated drug toxicity was the leading cause of unnatural death among youth during this period, and has been exacerbated by the introduction of fentanyl into the unregulated drug supply, which is implicated in 83% of youth deaths during this period (BC Coroners Service, 2024).

The crisis disproportionately affects marginalized youth populations, notably those experiencing homelessness, mental health conditions, and intergenerational trauma. The distribution of deaths reveals a concentration in specific health regions, notably Fraser Health, with 32%, and Island Health, with 28% of youth deaths (BC Coroners Service, 2024). Youth aged 17 to 18 represent 60% of fatalities, with females constituting 51%, a notably higher proportion compared to adult populations (BC Coroners Service, 2024). Most deaths occurred in private residences (73%), with over half of the youth using substances alone, underscoring the risks associated with isolation. About two-thirds of the decedents had

accessed current or previous services through the Ministry of Children and Family Development, and 67% had either a documented mental health diagnosis or anecdotal evidence of a mental health disorder. Youth navigating these risks contend with intersecting challenges shaped by developmental vulnerabilities, socio-economic disparities, and fragmented service systems, including education, child welfare, juvenile justice, and Indigenous governance structures (Patton et al., 2016). This convergence of risk factors and systemic inadequacies underscores the urgent need for tailored, culturally sensitive, youth-specific harm reduction and recovery services within the broader public health response. Youth substance use remains a critical issue with multifaceted social, developmental, and public health implications. In Canada, adolescents encounter a range of risk factors, including peer pressure, familial stressors, and mental health challenges (Canadian Centre on Substance Use and Addiction, 2025).

Within British Columbia, harm reduction services expanded significantly in response to escalating overdose deaths, but have recently faced public backlash. The Auditor General of BC (2024) criticized the government's harm reduction efforts for lacking province-wide minimum service standards, failing to address persistent barriers such as municipal resistance and staffing shortages, focusing too heavily on urban areas at the expense of rural and Indigenous communities, relying on insufficient and outdated planning and evaluation, and providing inadequate public reporting on program performance. This criticism has led to several significant policy reversals. Most notably, BC's three-year drug decriminalization pilot project, launched in January 2023, was substantially rolled back in April 2024 when the province reinstated criminal penalties for drug use in most public spaces, retaining only narrow exceptions for private residences, licensed consumption sites, and overdose prevention facilities (BC Civil Liberties Association, 2024; Government of British Columbia, 2024). Simultaneously, overdose prevention sites in Vancouver and Nanaimo were closed,

and several municipalities enacted bylaws effectively banning public drug consumption (BC Civil Liberties Association, 2024).

Concurrently, there has been a growing emphasis on involuntary care in British Columbia under the Mental Health Act, which permits the detention and compulsory treatment of individuals deemed incapable of making informed decisions or presenting an imminent risk to themselves or others (Health Justice, 2023; CBC News, 2025). Trends indicate that involuntary admissions for substance use disorders rose by 139% between 2008 and 2018, now constituting one in five involuntary hospitalizations (Jackson et al., 2024). Similarly, youth involuntarily admitted for treatment increased by 169% over the same timeframe, underscoring an escalating reliance on compulsory interventions among young populations (Representative for Children and Youth, 2021). This highlights the need for treatment and recovery frameworks that meet young people's needs before they escalate to the point of being a risk to themselves or others, and leads to the question of what, if any, successful methods are being explored and applied in communities and services towards this goal.

Background

Threshold Housing Society is a non-profit community organization in Greater Victoria, BC, dedicated to providing safe, stable, and supportive transitional housing and life skills programming for vulnerable youth at risk of homelessness (Threshold Housing Society, 2025). The organization's Supportive Recovery Program (SRP) is a residential harm reduction program that provides trauma-informed, non-judgmental care and flexible, individualized support to youth aged 15 to 21 who are navigating substance use challenges, aiming to reduce harm and promote recovery without requiring abstinence. SRP's work exists at the intersection of a pragmatic focus on minimizing immediate negative consequences (harm reduction) and the holistic pursuit of improved well-being and autonomy (recovery),

conducted in the context of working with marginalized young people (child and youth care). The Threshold Housing Society's SRP is innovative in that they do not require complete abstinence in order for a youth to participate in programming or to be considered successful.

My interest in this research is shaped by my academic background in child and youth care (CYC), where strengths-based relational practice emphasizes the importance of authentic, supportive relationships and the recognition of young people's inherent capacities and agency (Garfat et al., 2018). This perspective aligns with my experience as a teacher in inclusive education, which seeks to create learning environments that honour diversity and ensure all youth are valued and meaningfully included in their own education. Additionally, I believe strongly in harm reduction, human rights, and the deservingness of youth to non-judgmental, contextually relevant support that prioritizes their safety, participation, and well-being. As a result, my approach to research centres youth voices, challenges traditional adult-driven models, and advocates for participatory, rights-based, and relational frameworks that address the complexities young people face in real life.

I became involved with the Threshold Housing Society in the summer of 2023, following several conversations with Dr. Doug Magnuson about his pre-existing involvement with the organization. As a CYC practitioner and high school teacher in the Greater Victoria area, I was familiar with Threshold Housing Society's work and eager to gain experience conducting community-engaged research with a values-driven organization at the forefront of culturally responsive youth housing and support services. I was drawn to this project largely because of my experience working with youth similar to the clients of Threshold, as well as my professional background in public school alternative education programs. My direct experience supporting youth who had accessed this recovery program positioned me well to help understand the ethically complex nature of CYC work with youth using high-risk substances. Through my research and relationship with Threshold Housing Society, I am

committed to developing and supporting collaborative programs that empower marginalized youth to lead meaningful, self-directed change in their lives, a quality that SRP embodies.

As a part of my MA research project with the School of Child and Youth Care at the University of Victoria, I wanted my final product to benefit the SRP community. Through meeting with the Threshold leadership team, we decided that creating a practice framework to help staff understand and articulate how their innovative program operates would be a valuable outcome of my research. This process has involved working with frontline practitioners and management staff to translate their day-to-day experiences, values, and practices into a coherent framework that can be communicated both internally and externally. In doing so, I documented how SRP operates and created a resource that strengthens staff confidence in articulating their approach, provides a tool for onboarding new team members, and contributes to a broader conversation about youth-centred, harm reduction recovery.

I am proud to maintain an ongoing professional relationship with Threshold Housing Society. In February 2025, I had the opportunity to present the Harm Reduction Recovery for Youth Framework alongside Kacie Stirrett, the manager of SRP, at the International Conference on the Prevention of Youth Homelessness in Toronto. This event brought together over 600 participants from across Canada and around the world to share evidence-based strategies, innovative program models, and policy solutions focused on preventing youth homelessness. In October 2025, we presented at the National Conference to End Homelessness in Montreal. These engagements have provided me with the opportunity to reflect on and refine my thinking and research, ensuring the framework accurately represents the organization’s values and practices.

Context

In addition to being beneficial to Threshold Housing Society as an individual organization, this research addresses a critical gap in the literature regarding the practical application of harm reduction strategies within youth recovery settings. While harm reduction is increasingly recognized as an effective approach in adult addiction treatment, there remains a paucity of tailored guidance for youth aged 15 to 21 years (Heward et al., 2024). This project translates SRP's frontline staff expertise into a concrete, actionable framework designed for implementation by any organization serving youth, while simultaneously contributing to academic discourse and future research on youth-focused harm reduction and recovery practices.

Historically, treatment and recovery programs have been grounded in abstinence-only approaches. The shifting nature of youth programs in British Columbia highlights the need for research on non-abstinence-based approaches to recovery. A scan of publicly available information listed on the various health authority websites in BC shows that service providers are increasingly embracing non-abstinence-based approaches. The landscape of bed-based youth substance use treatment and recovery programs comprises 16 residential programs distributed across five regional health authorities. Vancouver Coastal Health administers five facilities, Fraser Health has three, Interior Health and Island Health each have two, and Northern Health has one. Program philosophies are evenly divided with eight abstinence-based and eight non-abstinence-based approaches, illustrating a balance of recovery paradigms within the sector. Age eligibility criteria typically encompass early adolescence through emerging adulthood, most commonly 13–18 years, with extensions to 24 years in select programmes, thereby aligning with developmental considerations. Lengths of stay typically range from less than three months to up to six months. Operated predominantly

by non-profit societies and community agencies, these bed-based services constitute a critical component of a continuum of care that bridges front-line harm-reduction efforts and longer-term recovery support for youth across British Columbia.

Table 1

Bed-Based Youth Recovery and Treatment Programs in British Columbia

Program:	Health Authority:	Ages Served:	Length:	Approach:
Nenqayni Wellness Centre	First Nations Health	13-18	1.5 weeks - 3 months	Abstinence
Orca Lelum Wellness Centre	First Nations Health	12-18	2.5 months	Non-Abstinence
Last Door Youth Addiction Treatment Program	Fraser Health	13-18	3-12 months	Abstinence
Phoenix Youth and Young Adult Treatment	Fraser Health	17-24	3-6 months	Non-Abstinence
Traverse Youth Substance Use	Fraser Health	13-18	<6 months	Abstinence
Westminster House Youth Program	Fraser Health	14-24	3 months	Abstinence
The Bridge Youth Recovery House	Interior Health	12-18	<3 months	Non-Abstinence
A New Tomorrow Youth Recovery	Interior Health	12-18	3 months	Abstinence
180° Youth Detox and Supportive Recovery	Island Health	13-19	<6 months	Non-Abstinence
Threshold Housing Supportive Recovery Program	Island Health	15-21	<4 months	Non-Abstinence
Nechako Youth Treatment Program	Northern Health	13-18	Not listed	Abstinence
Carlile Unit at the HOpe	Vancouver	17-25	2-3 weeks	Abstinence

Centre	Coastal Health			
Peak House	Vancouver Coastal Health	13-18	2.5 months	Abstinence
Young Bears Lodge	Vancouver Coastal Health	13-18	1-4 months	Non-Abstinence
The Foundation Program	Vancouver Coastal Health	16-24	Not listed	Non-Abstinence
Directions Youth Haven	Vancouver Coastal Health	16-21	Not listed	Non-Abstinence

Research Question and Project Objectives

Research Question:

Throughout my engagement with SRP, I have been impressed by its dynamic, passionate, and empathetic ethos. However, I observed that the organization would benefit from a cohesive framework to organize and articulate the complexity of its work. Around-the-clock harm-reduction-oriented care for a diverse population of youth with high-risk substance use does not fit neatly into a pre-existing recovery model; in fact, SRP may be unique in its approach. My overarching goal with this project is to support Threshold Housing Society by developing a framework that clarifies and organizes the complex work conducted at SRP for both internal and external educational purposes. Therefore, the research question I developed was: “How can harm reduction practices, as identified through staff experiences and program documentation of the Threshold Housing Society’s Supportive Recovery Program (SRP), be translated into a cohesive practice framework?”

Project Objectives:

Creation of a Cohesive Practice Framework

The primary objective of this project is to develop a cohesive and structured practice framework for the Threshold Supportive Recovery Program (SRP). The resulting Harm Reduction Recovery for Youth (HRR-Y) framework is grounded in the lived experiences and expertise of frontline staff, informed by detailed staff interviews and end-of-shift logs. The framework organizes and represents the complex practices of the SRP staff in a tiered system, encompassing interventions from relational residential care to supervised safer substance use.

Organization and Professionalization of Staff Practices

The secondary goal is to assist with the organization and professionalization of the SRP staff's day-to-day practices. By clearly defining the roles, interventions, and philosophies within the program, the framework supports consistent, evidence-based, and compassionate care delivery aligned with harm reduction and recovery principles.

Development of a Communication and Training Document

The framework is intended as a practical document for internal use, designed to enhance communication among staff and support staff development. It will serve as both a training and onboarding resource, helping new and existing staff to understand and apply harm reduction and recovery-oriented approaches effectively within the SRP.

Contribution to the Field of Harm Reduction and Recovery

Beyond immediate programmatic application, the project aims to contribute to the broader field of harm reduction and youth recovery. By developing a replicable and adaptable framework, I aim to inform and inspire similar programs beyond SRP. The HRR-Y framework provides a foundation for advancing scholarly and practical understandings of integrated harm reduction and recovery approaches tailored to youth populations.

Chapter Two: Literature Review

While conducting a review of the literature, I focused on three intersecting concepts: harm reduction, recovery, and relational CYC practice as they relate to adolescent substance use interventions. The convergence of these approaches represents a critical area of inquiry, particularly given the escalating rates of youth substance use, overdose deaths, and co-occurring challenges such as homelessness and mental health crises (Sawyer et al., 2018; Avci, 2025; Nawi et al., 2021). Traditional binary approaches that position harm reduction and recovery as opposing philosophies have proven inadequate for addressing the complex, multifaceted needs of young people navigating substance use (Best & Lubman, 2012; Kelly et al., 2018). This review establishes the theoretical foundations of each approach, synthesizes emerging trends toward integration, and identifies critical gaps that necessitate further research into how relational practice approaches can bridge these traditionally separate paradigms to create more effective, youth-centred interventions.

The Evolution and Tensions Within Harm Reduction

The harm reduction paradigm has undergone significant conceptual evolution since its emergence as both a pragmatic intervention strategy and philosophical framework (Logan & Marlatt, 2010; Marlatt, 1996; BC Centre for Disease Control, 2025; National Institute on Drug Abuse, 2025). Initially positioned as a public health response that prioritizes risk mitigation over abstinence mandates, harm reduction has expanded beyond its utilitarian origins to encompass broader principles of human dignity, anti-stigma advocacy, and individual agency (Harm Reduction International, 2019; Szalavitz, 2021). The empirical foundation supporting harm reduction interventions remains robust, with consistent evidence demonstrating reductions in overdose fatalities, infectious disease transmission, and mortality rates across diverse populations and settings (Deering et al., 2011; MacArthur et al., 2014;

Marshall et al., 2011; Padgett et al., 2006; Platt et al., 2017; Walley et al., 2013; Wodak & Cooney, 2006; World Health Organization, 2014). In practice, interventions such as needle exchange services, drug checking, naloxone distribution, and supervised consumption sites have been shown to lower overdose fatalities and reduce rates of infectious disease transmission (Canadian Centre on Substance Use and Addiction, 2024; Marshall et al., 2011; Platt et al., 2017; Potier, 2014; Walley et al., 2013; World Health Organization, 2014). Housing-first initiatives that prioritize providing stable living situations and peer-led outreach models further demonstrate the promise of harm reduction in enhancing housing stability, mental health, and service engagement (Deering et al., 2011; Padgett et al., 2006).

While the preponderance of research supports the effectiveness of harm reduction, the field is not without controversy. Critics claim there is a contradiction between its utilitarian emphasis on aggregate harm reduction and its simultaneous commitment to individual autonomy and social justice (Cawley & Dragone, 2023; King, 2020; Mangham, 2001). This tension manifests most clearly in resource allocation decisions, where interventions producing the most significant statistical reductions in harm may inadvertently marginalize individuals whose recovery preferences align with abstinence-based approaches or holistic wellness models (Mangham, 2001). Furthermore, the moral hazard critique, which suggests that comprehensive safety nets may inadvertently perpetuate cycles of substance use, speaks to unresolved questions about the relationship between immediate harm mitigation and long-term behavioural change (Mangham, 2001). To that end, Humphreys (2024) attributes some of the disillusionment with harm reduction policies amongst the general public to a lack of uptake in recovery or treatment services amongst people who use substances. Lastly, youth-specific applications of harm reduction introduce additional layers of complexity, including ethical, developmental, and legal considerations such as consent and protective oversight (BC Centre on Substance Use, 2023; Heward et al., 2024). Critics argue that

applying harm reduction principles to minors risks normalizing substance use during critical developmental periods, while proponents contend that punitive alternatives drive young people away from essential health services (King, 2020; Mangham, 2001). Advocates recommend further research on medication-assisted treatment for recovery and harm reduction approaches for adolescents (Finch et al., 2020).

Advocates of harm reduction underscore its empirical grounding and alignment with social justice by demonstrating that harm reduction interventions consistently reduce fatality rates, decrease transmission of bloodborne infections, and enhance access to social supports for marginalized populations, while actively challenging punitive policies that disproportionately criminalize and stigmatize people who use drugs (Jegede, 2024; Pauly, 2008; Ritter & Cameron, 2006). Evidence suggests that harm reduction approaches bolster service engagement, enhance quality of life, and lower mortality rates (Deering et al., 2011; MacArthur et al., 2014; Padgett et al., 2006; Wodak & Cooney, 2006). Needle and syringe programs have been associated with significant declines in HIV transmission, and supervised injection facilities have been linked to lowered overdose rates and improved treatment engagement (Marshall et al., 2011; Wodak & Cooney, 2006). Interventions such as supervised injecting facilities, injection paraphernalia provision, and information/education approaches demonstrated only tentative support for reducing risk behaviours (MacArthur et al., 2014).

The Recovery Movement: From Abstinence to Wellness

The recovery movement has undergone a fundamental paradigmatic shift from its abstinence-centred origins toward more inclusive, wellness-oriented conceptualizations (Davidson, 2016; Day et al., 2025; Eddie et al., 2019; Laudet & Humphreys, 2013; Sinclair et al., 2024; White, 1998; White, 2007; Wilson & Smith, 1939). While the term “recovery” can also apply to the process of healing from other mental or physical health illnesses, this review focuses on recovery as it applies to substance (mis)use (Bartram, 2021). Early

conceptualizations of recovery, such as Alcoholics Anonymous, centred almost exclusively on achieving and maintaining abstinence. In contrast, more recently developed secular approaches, such as SMART Recovery and LifeRing, emphasize self-empowerment, cognitive-behavioural strategies, and practical skills for change with similar outcomes when controlling for participant motivation (Beck et al., 2017; Kaskutas, 1994; Kelly et al., 2017; Kelly et al., 2023; Wilson & Smith, 1939; Zemore et al., 2018; Zemore et al., 2018). Table 2 provides an overview of the most popular recovery organizations and their positions on abstinence. Both abstinence and non-abstinence-based approaches can be found in recovery programs in BC, and it is common for recovery programs to support residents in attending the recovery group of their choice (New Roads Therapeutic Recovery, n.d.). The Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) characterizes recovery as a transformative, individualized process focused on enhanced wellness and the pursuit of personally meaningful goals, recognizing relapse as an anticipated component of recovery rather than an outright failure.

Table 2

Comparison of Major Mutual Aid Recovery Groups

Group	Philosophy	Position on Abstinence
Alcoholics Anonymous & Narcotics Anonymous	12-step, spiritual, abstinence-focused	Strongly promotes lifelong total abstinence as the only goal (Kelly et al., 2017; Zemore et al., 2018).
SMART Recovery	Secular, cognitive-behavioural, self-management	Flexible: supports both abstinence and moderation, but most members pursue abstinence (Zemore et al., 2018; Kelly et al., 2023).

LifeRing Secular Recovery	Secular, peer-led, self-empowerment	Flexible: supports abstinence but allows self-defined goals; less stringent than AA (Zemore et al., 2018; Zemore et al., 2017).
Women for Sobriety	Women-only, self-empowerment, positive thinking	Strongly promotes abstinence as the primary goal (Zemore et al., 2018; Kaskutas, 1994).

In recent scholarship, the growing recognition that recovery is not a linear process and that individuals may move back and forth between stages of change is becoming more prevalent (Best & Lubman, 2012; DiClemente & Crisafulli, 2022; Kelly et al., 2018). This evolving perspective has led to the development of Recovery-Oriented Systems of Care (ROSC), which expands the notion of recovery beyond formal group settings to integrate services across healthcare, housing, employment, and peer support to address the diverse needs of people in recovery (Ashford et al., 2018; SAMHSA, 2012). These systems recognize the value of lived experience and peer-led interventions, which have been demonstrated to enhance engagement, reduce stigma, and improve outcomes, including reduced severity of substance use, increased stability in housing and employment, improved social functioning, and enhanced quality of life (Ashford et al., 2018).

Some scholars have reframed harm reduction and recovery as complementary, rather than dichotomous, approaches, illustrating how safer-use strategies can mitigate immediate risks and establish a more stable base for long-term change (Bartram, 2021; Best & Lubman, 2012). This shift enables practitioners to focus not on whether clients are getting high, but whether they are getting better (Szalavitz, 2021). This integrative perspective highlights the importance of tailoring interventions to individual contexts, combining the adaptability of harm reduction with the holistic approach of recovery-oriented care (Kelly et al., 2018).

However, this perspective is not ubiquitous; abstinence as the ultimate goal of recovery remains a prevalent notion, with the Government of Alberta, BC's neighbouring province, recently unveiling a sweeping public health policy change that defines recovery as a consistent pursuit of "a substance-free life" with scant mention of harm reduction measures (Government of Alberta, 2025). While there is a consensus that supporting recovery is important, there is significant disagreement about the most effective way to achieve recovery.

Youth Contexts: Developmental Considerations and Service Complexities

Adolescence is a developmental period characterized by rapid biological, psychological, and social changes, which can increase vulnerability to substance use and related challenges (Winters & Botzet, 2011; Winters et al. 2011; Sawyer et al., 2018). During this time, heightened impulsivity, sensation-seeking, and the search for identity are normative but may also contribute to risk-taking behaviours, including substance use (Cleveland et al., 2008; Steinberg, 2005). Youth may encounter substance use or homelessness through complex pathways involving trauma, family dysfunction, peer influence, and socio-economic adversity (Avci, 2025; Nawi et al., 2021). For example, risk factors such as family conflict, low parental supervision, association with substance-using peers, and exposure to community violence are consistently linked to increased substance use among adolescents (Avci, 2025; Cleveland et al., 2008; Kliewer & Murrelle, 2007; Woodward et al., 2023). Conversely, protective factors, such as positive family interactions, school connectedness, structured leisure activities, and supportive adult relationships, can buffer against these risks and promote resilience (Avci, 2025; Woodward et al., 2023). The presence of multiple protective factors is associated with lower rates of substance use and better overall outcomes (Cleveland et al., 2008; Kliewer & Murrelle, 2007).

Ethical and legal considerations further complicate service provision for youth. For instance, parental consent requirements may limit access to certain treatments for minors, and

some stakeholders express concern that harm reduction approaches for youth could be perceived as condoning or normalizing substance use (Avci, 2025; Nawi et al., 2021). However, evidence suggests that developmentally appropriate, non-punitive interventions, such as family-based support, school-based programs, and culturally informed care, are more effective in engaging youth and reducing harm (Avci, 2025; Woodward et al., 2023). Even proponents of harm reduction practices for youth acknowledge that the approach is inherently fraught with ethical tensions, often requiring practitioners to navigate significant uncertainty, emotional discomfort, and the need to accept the limits of their ability to resolve all risks, especially when working with high-risk youth (Owens & Nuttgens, 2021). Data collected from youth also indicate that barriers to accessing harm reduction services persist, including self-stigma, difficulties with service navigation, inadequate service delivery, and negative interactions with providers (Beck et al., 2024).

Recent research has highlighted that integrated models of care, which combine familial support, school engagement, and developmentally tailored interventions, are associated with positive outcomes, including reduced substance use, improved mental health, and increased engagement in education and community life (Avci, 2025; Woodward et al., 2023). Approaches that adapt to the changing dynamics of youth development by emphasizing harm reduction, trauma-informed practice, and cultural responsiveness are increasingly recognized as appropriate and effective (Avci, 2025; Nawi et al., 2021; Winer et al., 2022; Woodward et al., 2023). Youth report that supportive social networks, meeting basic needs, and positive provider interactions can facilitate sustained access to harm reduction care and support among youth who use drugs. These factors help overcome barriers such as stigma, service navigation difficulties, and negative provider interactions, thus promoting better engagement and continuity of care in harm reduction services (Beck et al., 2024).

Therapeutic Residential Care: A Potential Bridge for Harm Reduction and Recovery

Therapeutic residential care (TRC) is a specialized form of out-of-home care for children and adolescents with complex needs, often relating to trauma, mental health issues, or behavioural challenges, who cannot be supported in family-based settings (Whittaker et al., 2016). An international consensus statement highlights TRC as a multidimensional environment that provides treatment, education, socialization, and protection, ideally in partnership with families and community resources (Whittaker et al., 2016; Daly et al., 2018). Research underscores the importance of trauma-informed, relationship-based practices, with trusting, supportive staff–youth relationships and positive social climates linked to better outcomes (McPherson et al., 2025; Leipoldt et al., 2017; Castro et al., 2024). However, the field faces challenges, including inconsistent implementation, limited youth participation in decision-making, and a lack of clarity around effective treatment mechanisms (Castro et al., 2023; Bellonci & Holmes, 2020). Evidence suggests that TRC should address both specific (e.g., treatment models, staffing) and non-specific (e.g., family involvement, youth history) factors, with family engagement and individualized approaches being particularly important (Castro et al., 2023; McNamara, 2020). While short-term improvements in mental health and functioning are documented, sustaining positive outcomes after discharge remains challenging, highlighting the need for ongoing support and further research into long-term effectiveness and quality indicators from the perspectives of young people themselves (Leipoldt et al., 2017; Castro et al., 2024).

While there is a notable gap in the literature regarding how to structure integrated harm reduction and recovery interventions within residential contexts, there is a clear need for research and new frameworks that explicitly combine these approaches through relational practice, offering a more nuanced, developmentally attuned, and youth-centred model of support. TRC is well-positioned to serve as a bridge between harm reduction and recovery for

youth. By providing a structured, supportive, and trauma-informed environment, TRC can integrate harm reduction strategies, such as reducing immediate risks and promoting safety, with recovery-oriented practices that foster long-term wellness, empowerment, and personal growth (Castro et al., 2023; Downey et al., 2015; Molina-Fernández & Arribas-Tiemblo, 2025). This integrative approach creates space for individualized care that meets youth where they are, supports incremental change, and accommodates both abstinence and non-abstinence goals, thus addressing the diverse and evolving needs of young people navigating substance use alongside co-occurring challenges (Castro et al., 2023; Molina-Fernández & Arribas-Tiemblo, 2025).

Chapter Three: Methodology

Project Design

This project utilized a qualitative, participatory research design to explore harm reduction and recovery-oriented practices among youth recovery support workers and SRP management staff. By centring the lived experiences and insights of those staff directly involved in youth recovery work, this approach ensured that the resulting framework was responsive to the needs of both the organization and the youth it serves. While data collection was conducted as part of a larger study, "Harm Reduction Practices in a Supportive Recovery Program", under Dr. Doug Magnuson, the data analysis and development of the HRR-Y theoretical framework were carried out specifically for this master's project.

Participants

Participants in this study included 17 youth recovery support workers, two SRP management staff and indirectly the ten youth residents. All participants were informed about the study's objectives, procedures, and any potential risks or benefits. The consent form outlined that participation was voluntary, with the option to withdraw at any time without penalty, supporting ethical engagement and participant autonomy. Although youth residents were not directly interviewed, data were collected and anonymized to protect their identities. They provided consent for the use of their data, including their patterns of substance use and the practices that staff believed addressed their needs (Appendix A). Youth Recovery Support Workers provided written consent for the use of their log entries and for participating in interviews (Appendix B).

Data Collection

After receiving ethics approval, the data collected were drawn in sequential phases from two primary sources:

Daily Staff Logs:

Staff recorded detailed daily logs documenting harm reduction practices, substance use interventions, and recovery-oriented strategies utilized. These logs provided insight into staff actions and the contexts in which harm reduction principles were applied. The questions staff answered were:

1. Was there a harm reduction practice you used today in your substance use interventions with this youth?
2. What was it specifically that was considered harm reduction? Please be as specific as possible.
3. Are you satisfied with how it went? Why or why not?

These questions were designed to gain an initial understanding of which daily recovery practices staff considered important as harm reduction interventions. The consent forms (Appendices A and B) also mention collecting information about the youths' learning goals (either with respect to informal life skills, formal education, or extracurricular pursuits), but this data was not collected due to a desire not to overburden the staff participants.

Semi-Structured Interviews

After gaining initial insights into how harm reduction practices function at SRP, according to the staff, it became clear that more in-depth data was required. I conducted a total of fourteen 20-30 minute-long interviews with SRP staff over Zoom to gain a deeper understanding of their perspectives on harm reduction, recovery, and the challenges they encounter while providing care. Open-ended questions encouraged discussion of specific approaches, successes, and areas for improvement. The interviews began by asking the staff to reflect on a time when they thought they were practicing harm reduction and why. Interviewees were asked about behavioural strategies, cannabis and nicotine-based strategies,

supervised use and how they constituted harm reduction. Gift cards were provided to staff as a token of appreciation for their participation.

Data Analysis

Thematic analysis, following Braun and Clarke's (2006) approach, was used to identify and organize key themes within the shift logs and interview data. Data from the shift logs were coded into themes, providing a preliminary understanding of how staff members conceived of doing harm reduction during their shifts. I conducted an in-depth reading and coding of the first two interviews, combining codes from the interview data with previously identified interventions from the daily staff log data. This initial coding process resulted in a preliminary set of codes that captured the main patterns and practices described by the participants. I then applied and tested them against the data from subsequent interviews to determine whether my initial themes adequately represented the experiences and perspectives of other participants. These preliminary themes enabled me to shape my subsequent interviews. Throughout this process, I remained reflexive and open to revising, expanding, or refining the codes as new insights or nuances emerged from the additional data. This iterative approach ensured that the final framework was both grounded in the lived experiences of participants and comprehensive across the dataset.

Additional feedback was gathered through staff meetings and multiple meetings with SRP management. This iterative, participatory process supported the co-creation of the HRR-Y practice framework, designed to guide SRP staff in delivering integrated, youth-centred harm reduction and recovery support, as well as communicating SRP's practices externally. This helped ensure that research outputs were relevant, actionable, and grounded in the lived experiences of those involved in practice settings (Cornish et al., 2023).

Ethical Considerations

This research on harm reduction practices in SRP has been approved by the University of Victoria's Human Research Ethics Board (HREB). While conducting this research, the following key considerations were taken into account to respect participants' dignity and privacy:

Privacy, Confidentiality, and Data Security

Data collected from staff logs were anonymized by SRP personnel before being shared with the researchers. Identifiable information was removed, and data was stored securely on a password-protected University of Victoria server, accessible only to the research team. To further safeguard anonymity, published results will include only aggregated data, and any unique details that could inadvertently identify participants will be excluded from reports and publications. After two years, all raw data will be permanently deleted, respecting long-term privacy.

Risk Mitigation and Participant Well-Being

Given the sensitive nature of the data about youth and the emotionally challenging and personal nature of the work for the staff, precautions were taken to mitigate potential concerns. Substance use patterns that could inadvertently identify youth participants to individuals who know them will be excluded from published materials. I strove to conduct interactions with participants in a trauma-informed manner with sensitivity applied to their psychological and emotional well-being.

Collaboration and Dissemination

The project has been developed in partnership with the Threshold Housing Society, reflecting a collaborative approach that honours the expertise and needs of SRP staff. Findings will be shared with the organization by creating a harm reduction recovery practice framework, along with presentations and facilitated discussions at staff meetings. Broader dissemination will include academic publications and conference presentations, contributing to the fields of harm reduction and youth recovery. Transparency is at the core of my research process, and participants will have the opportunity to access findings relevant to their experiences.

Limitations

A primary limitation of this research methodology was the small sample size based on a single recovery program, which may restrict the generalizability of the findings and limit their applicability to broader populations. Similarly, the absence of a comprehensive co-designed process with affected youth constrained the study's ability to fully capture youth perspectives and ensure the research addressed their priorities and lived experiences. Another notable limitation is the lack of researcher triangulation, as having only one researcher involved in the interpretation and analysis of data may have introduced potential biases that could have been mitigated through collaborative review and multiple viewpoints.

Chapter Four: Results

Harm Reduction Recovery for Youth (HRR-Y) Framework

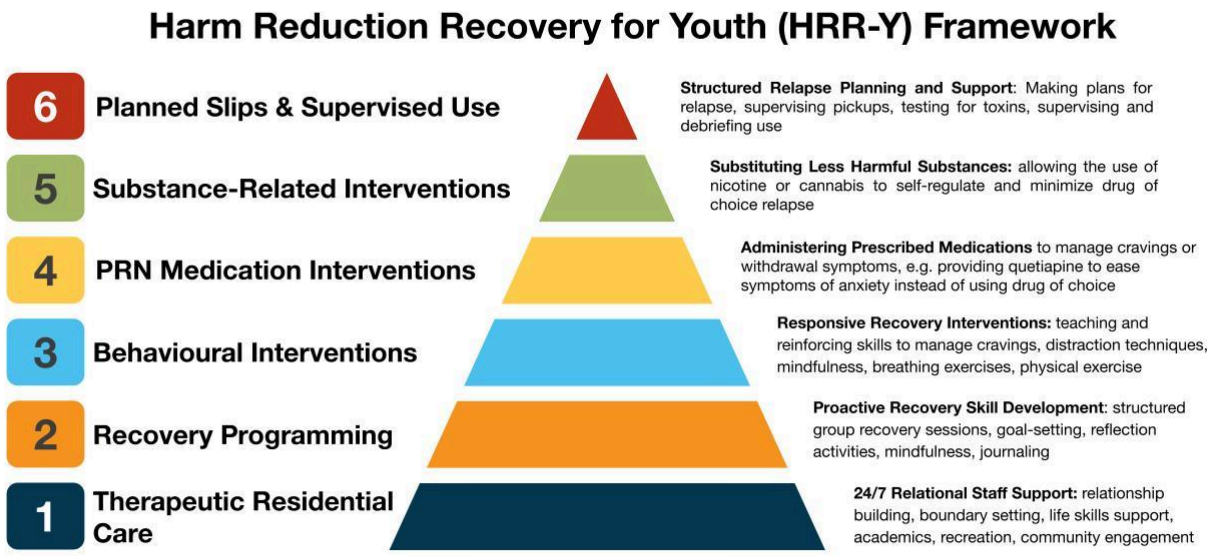
This six-tiered framework emerged from this research project and provides a holistic, multi-level approach to supporting youth engagement with substance use services. It is designed to guide management staff in internal communication, external collaboration, and training, acknowledging that youth often present with complex needs (Bellonci & Holmes, 2021; Ungar et al., 2014). The framework is fundamentally rooted in three core theoretical underpinnings: Therapeutic Residential Care (TRC), Recovery principles, and Harm Reduction strategies. This structure recognizes that youth trajectories are often complex and non-linear (DiClemente & Crisafulli, 2022; White, 2007).

The framework's design reflects the integration of theory with practical frontline data derived from the experiences of service professionals, ensuring that the framework addresses real-world challenges (Ashford et al., 2018; Fast et al., 2022). The emphasis on TRC in Tier 1 is grounded in relational theory, which is validated by studies incorporating young people's beliefs and experiences to define quality care standards (Castro et al., 2024; Garfat et al., 2018; McPherson et al., 2025). Crucially, the highly acute Harm Reduction Tiers (5 and 6) are a direct structural response to frontline practical realities and the severe risks of the toxic drug crisis (BC Coroners Service, 2024). Specifically, the concepts of supervised use and planned slips (Tier 6) address key recommendations and findings from youth who use drugs, who emphasized the necessity of staff and environments that focus on mitigating danger without judgment (Canêdo et al., 2022; Fast et al., 2022). By making the tiers non-sequential, the framework acknowledges the lived experience of frontline professionals who often manage complex scenarios where youth may require both structured recovery support (Tier 2/3) and immediate access to acute harm reduction measures concurrently (Tier 6), while also

recognizing the ethical tensions and systemic barriers inherent in this multifaceted work (DiClemente & Crisafulli, 2022; Owens & Nuttgens, 2021).

Figure 1:

Harm Reduction Recovery for Youth (HRR-Y) Framework Diagram



Theoretical Underpinnings

Therapeutic Residential Care (TRC)

TRC is the essential foundation of the framework, emphasizing that the relationship between staff and youth is the intervention (Garfat et al., 2018; Stuart, 2009). High-quality TRC provides the 24/7 relational context necessary for positive youth outcomes (Castro et al., 2023; Daly et al., 2018). The residential environment is specifically designed to be trauma-informed (BC Ministry of Children and Family Development, 2013; Canadian Centre on Substance Abuse, 2014; SAMHSA, 2014), recognizing the profound impact of trauma on youth and their subsequent service needs.

Harm Reduction

Harm Reduction involves practical strategies and ideas aimed at minimizing the negative consequences associated with drug use, without requiring abstinence (Harm Reduction International, 2021; Kimmel et al., 2021; National Harm Reduction Coalition, 2020). This approach is particularly critical in the context of the toxic, unregulated drug crisis and recognizes that requiring immediate cessation can be unrealistic or dangerous for some youth (BC Coroners Service, 2024; Fast et al., 2022; Marlatt, 1996).

Recovery

Recovery is defined as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential (Best & Lubman, 2012; Laudet, 2007; SAMHSA, 2012). This framework embraces both traditional abstinence-based outcomes (White, 1998, 2007) and non-abstinence goals, such as reduced drug use, which is increasingly recognized as a valid and positive outcome, particularly for individuals with stimulant use disorders (Amin-Esmaeili et al., 2024). Recovery programming often utilizes evidence-based psychosocial treatments recommended for adolescents (Fadus et al., 2019; National Institute on Drug Abuse, 2020).

Framework Structure

The framework is segmented into a six-tiered triangle organized by theme, with preferred, normalizing interventions at the base and progressively more intensive harm reduction strategies towards the apex. Tier 1: Therapeutic Residential Care is the relational tier and is considered the essential base of the rest of the framework. This tier establishes safety, structure, and community, operating on the theme of building a strong foundation for the subsequent tiers (Brendtro et al., 2002; Daly et al., 2018). Tier 2: Recovery Programming and Tier 3: Behavioural Interventions focus on building recovery skills and incorporate structured programming (Tier 2) and individual skill development (Tier 3) and are designed

to support movement toward recovery goals and represent the theme of recovery skill building (Fadus et al., 2019; Steele et al., 2020). The harm reduction-oriented tiers encapsulate Tier 4: PRN Medication Interventions, Tier 5: Substance Replacement, and Tier 6: Planned Slips & Supervised Use. These tiers focus on mitigating acute risks and immediate danger. They involve strategies ranging from clinical/pharmacological support (Tier 4), substitution (Tier 5), to critical overdose prevention and supervised use measures (Tier 6) (BC Centre for Disease Control, 2023; Interior Health Authority, 2025).

The overarching goal is for youth to experience individually defined success and safety through engagement with the foundational, less intensive tiers (Tiers 1–3), while maintaining non-judgmental access to the more intensive, acute tiers (Tiers 4–6) when needed (Canêdo et al., 2022; Fast et al., 2022). By offering a comprehensive range of interventions, the framework ensures youth safety, minimizes harm, and promotes engagement throughout the entire recovery process (Kimmel et al., 2021; Winer et al., 2022).

The pyramidal arrangement generally reflects the increasing intensity, clinical invasiveness, or severity of the interventions (Saito et al., 2020). Tier 1 represents the universal, foundational care environment, while Tiers 5 and 6 represent specialized, acute responses necessary for immediate risk mitigation, such as supervised use in environments facing overdose advisories (CHEK News, 2025; Marshall et al., 2011). It is crucial to recognize that the tiers are not intended to be accessed sequentially, but instead as needed by circumstance (DiClemente & Crisafulli, 2022; White, 2007). A youth may engage with an intervention from any tier at any point based on their immediate need, with relationships underpinning everything (Garfat et al., 2018; Stuart, 2009). The framework recognizes that individuals may concurrently require evidence-based behavioural treatments (Tier 3) while also needing access to acute harm reduction measures (Tier 6) due to the non-linear nature of substance use recovery and the acute risk of the toxic drug supply.

Tier 1: Therapeutic Residential Care

Overview

Tier 1 involves creating a 24/7 therapeutic environment, fostering relationships, developing life skills, and building community. This creates a strong relational foundation and supportive environment for youth and staff from which they can apply the remaining tiers as needed. Building therapeutic relationships is the primary intervention in this tier, enabling staff to effectively respond to the needs of the youth in a meaningful way, rather than simply managing surface-level symptoms (Anglin, 2002; Garfat et al., 2018; Stuart, 2009). High-quality TRC is crucial, particularly for youth with complex needs (Bellonci & Holmes, 2021; Daly et al., 2018). Building relationships and assisting youth in their positive life activities can have a positive, normalizing effect (Anglin, 2002), which ultimately supports them in their recovery journey.

Staff Examples

- Creating a therapeutic environment for open discussion without shame
- Building trust through consistent presence, warmth, and emotional safety
- Offering engaging activities: exercise, arts, birthday parties, mountain biking
- Tailoring staff approaches from high to low guidance based on youth needs
- Providing aftercare and continuous relational support post-slip

Key Concepts

Social Climate: A supportive social climate is a significant determinant of positive youth outcomes (Castro et al., 2023; Leipoldt et al., 2017). This includes fostering an environment where youth are supported (Brendtro et al., 2002) and staff are skilled at managing pain (Anglin, 2002; Modlin, 2019). Staff-resident relationships thus form the foundation of the recovery ecosystem.

Trauma-Informed Approach: Effective service delivery is contingent upon the integration of trauma-informed practice, acknowledging the profound impact of trauma on youth and their service needs (BC Ministry of Children and Family Development, 2013; Canadian Centre on Substance Abuse, 2014; SAMHSA, 2014). Even if staff have the best intentions, it is important to recognize that healing cannot be rushed and that each youth will move at their own pace. This ensures that services are responsive to the unique circumstances, resilience, and readiness of each individual.

Tier 2: Recovery Programming

Overview

This tier involves structured sessions: goal-setting, craving ratings, reflections, and group therapy. It focuses on structured programming aimed at achieving and sustaining recovery, defined broadly as improving health, wellness, and self-directed living (Best & Lubman, 2012; SAMHSA, 2012). Programming may include recovery support services and 12-Step approaches, as well as secular approaches such as SMART Recovery or LifeRing, which have a positive impact on adolescent outcomes (Kelly & Urbanoski, 2012; Sinclair et al., 2024).

Staff Examples

- Implementing recovery groups and mindfulness practices for emotional well-being
- Journaling, teaching coping skills, and group reflection to normalize relapse
- Teaching self-awareness through check-ins to recognize triggers
- Tailoring programming to meet the needs of the group

Key Concepts

Flexible Evidence-Based Approaches: While abstinence is a primary goal, research increasingly validates reduced drug use as a positive and meaningful outcome, particularly

for individuals struggling with stimulant use disorders (Amin-Esmaeili et al., 2024). Most youth who access SRP are doing so without the immediate goal of strict abstinence, so secular approaches such as cognitive-behavioural approaches that help youth achieve healthier relationships with substance use are a natural fit. (Das et al., 2016; Fadus et al., 2019; National Institute on Drug Abuse, 2020; Waldron & Turner, 2008).

Tier 3: Behavioural Interventions

Overview

Tier 3 involves responding to youth triggers and cravings to use substances more than their stated recovery goals. This could include distraction, mindfulness, breathing exercises, and physical activity, which are essential for managing both internal and external triggers for relapse (DiClemente & Crisafulli, 2022; Gaolaolwe et al., 2025). These psychoeducational elements are central to relapse prevention and are integrated into approaches like SMART Recovery (Beck et al., 2017). Motivational Interviewing (MI) is an evidence-based approach for changing adolescent substance use behaviour, strengthening motivation, and resolving ambivalence in a collaborative (Barnett et al., 2012; Jensen et al., 2011). This approach is well-positioned for scenarios such as these, but staff should be empowered to tailor interventions and use their professional judgement on a case-by-case basis.

Staff Examples

- Using distraction techniques: art, walking, TV, and conversations to cope with cravings
- Engaging in physical activities to regulate emotions and reduce urges
- Using cannabis check-in conversations to explore sensations, cravings, and motivations
- Cost-benefit analyses with reflective activities for intentional substance use

- Balancing gentle enforcement with compassion for accountability

Key Concepts

Skill Building: Interventions focus on strategies such as distraction techniques, mindfulness exercises, and controlled breathing to enhance self-efficacy in managing cravings (Gaolaolwe et al., 2025).

Relationships are Critical: Trusting, safe, and supportive staff-youth relationships are foundational, offering consistency and stability during moments of vulnerability and potential relapse.

Individualized Care: There is no one-size-fits-all approach in recovery. Staff must continuously balance professional judgement, the best interests of the youth, and an understanding of trauma-informed practice to deliver care that adapts to the unique needs, goals, and pace of each individual resident.

Tier 4: PRN Medication Interventions

Overview

This tier involves administering prescribed medication to manage cravings or withdrawal symptoms, e.g., quetiapine for anxiety/withdrawal and addresses acute clinical symptoms through the administration of pro re nata (PRN) medication (Saito et al., 2020). PRN interventions are used to manage withdrawal, anxiety, or agitation (Hoffmann et al., 2021), thereby reducing the risk that youth will resort to using unregulated substances for self-medication (Winer et al., 2022).

Staff Examples

- Use of PRN medications (e.g. quetiapine) for anxiety, cravings, withdrawal
- Emphasizing youth choice in medication decisions

- Encouraging PRN before cannabis/nicotine when appropriate
- Monitoring medication effects and interactions with substances

Key Concepts

Ethical Administration: Strict standards of care must be adhered to when administering psychotropic medication to children and youth in residential settings (Ontario Ministry of Children and Youth Services, 2009).

Least Restraint Principle: Medication utilized for managing acute distress or agitation must comply with the principle of least restraint, a core guideline in child and youth mental health services (Child Health BC, 2022).

Tier 5: Substance-Related Interventions

Overview

Tier 5 applies the principles of harm reduction, which focus on minimizing the negative consequences of substance use, rather than requiring immediate abstinence. Specifically, substituting less harmful substances than the residents' drug of choice, e.g., nicotine or cannabis, to minimize drug of choice relapse. (Harm Reduction International, 2021; Kimmel et al., 2021; National Harm Reduction Coalition, 2020). Helping youth use at a safer, more predictable rate and manner is an important pillar of this framework.

Staff Examples

- Allowing the use of safer substances and harm reduction kits with clean supplies
- Safe cannabis access policies with usage frequency restrictions
- Preference for labelled dispensary products over homemade edibles
- Drug testing and supervised proposals for planned slips
- Allowing youth choices for cannabis/nicotine to meet self-regulation needs

Key Concepts

Balancing Structure and Flexibility: Staff support youth in meeting their self-regulation needs while introducing consistency and boundaries. Flexibility enables safer choices through harm reduction, while structure provides accountability and prevents the development of unsafe patterns.

Substitution Evidence: Research indicates that cannabis substitution can be a safer alternative for some individuals, aiding self-regulation and reducing the use of more dangerous drugs (Heward et al., 2024; Lau et al., 2015). The goal is not to get high, but to use less harmful substances more safely than youth otherwise world.

Reducing Overall Harm: Providing access to substances like nicotine, if this minimizes the immediate risk of youth seeking and using highly toxic, unregulated substances, aligns with the philosophy of reducing overall immediate harm (Interior Health Authority, 2025).

Tier 6: Planned Slips & Supervised Use

Overview

This is the most acute harm reduction tier, designed to provide safety during inevitable periods of drug use (slips) to prevent unregulated drug toxicity deaths (BC Coroners Service, 2024; Canêdo et al., 2022). Planning for potential relapses minimizes harm, e.g., supervising pickups, testing for toxins, supervising and debriefing use, and ensuring that any instances of use are as safe as possible. Youth emphasize the need for non-judgmental environments where staff prioritize mitigating danger over abstinence (Fast et al., 2022).

Staff Examples

- Robust planned slip policies requiring multi-step plans including cost-benefit analysis, supervised consumption, drug testing, and post-use check-ins
- Flexibility in escalating from coping strategies to planned slips with clear communication, safety planning, and youth consent
- Emphasizing that relapse is normalized and providing ongoing support to prevent shame/guilt cycles.

Key Concepts

Overdose Prevention: The functions of this tier mirror those of Supervised Consumption Sites (SCS), which are recognized as necessary public health interventions proven to reduce overdose mortality (Canadian Institute for Substance Use Research, 2021; Marshall et al., 2011; Ontario HIV Treatment Network Rapid Response Service, 2024). Providing controlled environments may involve elements of Episodic Overdose Prevention Services (eOPS) (BC Centre for Disease Control, 2023). Supervised use allows crucial opportunities for connection, debriefing, and reconnection back to foundational programming (Fast et al., 2022).

Chapter Five: Conclusion

This project developed the Harm Reduction Recovery for Youth (HRR-Y) framework, a structured and integrated practice framework based on the experiences of frontline staff at a supportive recovery program for youth in British Columbia. The framework addresses a significant gap in youth substance use interventions by combining harm reduction and recovery-oriented care within a residential therapeutic setting. Amidst an ongoing toxic drug crisis and shifting policy landscapes, the HRR-Y framework offers a flexible and multi-tiered approach that accounts for developmental, ethical, and relational complexities in supporting youth aged 15 to 21 years.

By grounding the framework in relational therapeutic residential care, the framework emphasizes the critical role of supportive relationships as the foundation for all interventions. This base fosters safety, community, and trauma-informed responsiveness, which are key for promoting youth engagement with various recovery and harm reduction strategies. The framework integrates harm reduction components such as medication interventions, substitution therapies, and supervised use to mitigate immediate risks associated with a contaminated, unregulated drug supply. Its tiered and overlapping design reflects the realities of youth substance use, recognizing relapse and non-linear recovery processes as common and expected.

This practical framework serves as a tool to help staff articulate and organize their innovative care framework for internal training and professional development, and to contribute to broader youth substance use treatment practices. It has served as the structure for conference presentations delivered on by Threshold Housing Society (Appendix C). It supports agencies seeking to implement non-abstinence-based, developmentally appropriate, and trauma-informed programs. The HRR-Y framework centres youth autonomy, dignity, and

safety while bridging the divide between harm reduction and abstinence-focused recovery approaches.

Limitations include the study's focus on a single site and limited direct youth participation, which may limit generalizability and overlook nuanced perspectives of the youth. Future research should incorporate participatory methods involving youth in the continued development and evaluation of the framework. Additionally, outcome studies are needed to assess the impact of the HRR-Y framework on the health, well-being, and substance use trajectories of youth.

Overall, this project advances a paradigm shift in youth substance use support by offering an integrative, relational, and pragmatic framework combining harm reduction and recovery. As youth substance use patterns evolve within complex social and policy contexts, the HRR-Y framework offers a compassionate, evidence-informed approach to supporting young people in reducing harm, enhancing autonomy, and pursuing wellness on their own terms.

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Appendix A: Resident Consent Form

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Participant Consent Form

Harm Reduction Practices in a Supportive Recovery Program (SRP)

As a resident in Threshold Housing Society's SRP, we are inviting you to participate in a study called Harm Reduction Practices in a Supportive Recovery Home (SRP). This study is being done by Doug Magnuson [redacted] and Lewis Rhodes [redacted]ug Magnuson is a professor in the dep[redacted] Psychology and Le[redacted] Lewis Rhodes is a Master's Student in the School of Child and Youth Care.

As a Graduate student, Lewis is required to conduct research as part of the requirements for a degree in Child, Youth, Family and Community Studies. It is being conducted under the supervision of Doug Magnuson and Bryan Silverman (bsilverman@uvic.ca).

Purpose: What Are We Doing?

We are interested in two SRP practices: harm reduction and supporting your learning goals.

As you know, staff write notes at the end of every shift about each time that you want to use substances. We asked them to add answers to two questions:

a) "Was there a harm reduction specific practice you used today in your substance use interventions?
b) What was it specifically that you consider to be harm reduction? Please be as specific as possible."

We want to count the number of times this happens, and we also want to read about what staff think counts as harm reduction. We would like your permission to see these records. If you agree, Kacie will upload just the answers to these questions to a folder on SRP's SharePoint folder and we will read them there.

We are also interested in the learning goals that you choose for yourself while in the program. We would like your permission to see the goal sheets that you fill out for the goal setting group and that you share with the group. Staff will remove your name from the goal sheets and Kacie will upload them to the SharePoint folder. We would like your permission to use what is in these records and your goal sheets for research.

Importance of this Research:

Harm reduction has not been studied much with young people, and neither have learning goals in recovery programs. We hope that this work will contribute to a better understanding of how this is done.

What is Involved for You:

Please review this consent form. Please decide whether you allow Threshold Housing Society to share these records with UVic researchers. Please ask questions if anything is unclear.

Voluntary Participation:

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation by contacting the researchers or an

Voluntary Participation:

Your participation is voluntary, in part and in whole. You may decline to let us collect any of your logs or you may ask us not to collect data about a specific incident. Consent is ongoing, and you may withdraw your permission at any time.

Anonymity:

No identifying information about you or residents will be collected, published, or shared. We will not reveal the status of your participation to the managers of Threshold.

Confidentiality:

Data will be accessed by us through a secure connection to a SharePoint folder. Information about you and your practice that could be used to identify you will not be used.

Dissemination of Results:

Lewis will be writing his master's thesis using this data, and Doug and Lewis are hoping to write an academic paper for publication. These will be shared with you and with Threshold staff.

Disposal of Data:

We would like to keep this data for two years after collection on the UVic server. Then it will be deleted.

Contacts:

You may contact Doug Magnuson or Lewis Rhodes at the email addresses in the first paragraph. You can also reach Doug by text or phone [redacted] and Lewis by text or phone [redacted]

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545) or (ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

_____	_____	_____
Name of Staff	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix B: Staff Consent Form

University of Victoria | Research Services

Staff Consent Form

Harm Reduction Practices in a Supportive Recovery Program (SRP)

As a Youth Recovery Support Worker are Threshold Housing Society's SRP, we are inviting you to participate in a study called Harm Reduction Practices in a Supportive Recovery Home (SRP). This study is being done by Doug Magnuson ([redacted] and Lewis Rhodes [redacted] Doug Magnuson is a professor in the department of Educational Psychology and Leadership Studies and Lewis Rhodes is a Master's Student in the School of Child and Youth Care.

As a Graduate student, Lewis is required to conduct research as part of the requirements for a degree in Child, Youth, Family and Community Studies. It is being conducted under the supervision of Doug Magnuson and Bryan Silverman ([redacted]

Purpose: What Are We Doing?

This research aims to examine and understand the implementation of harm reduction strategies within a supportive recovery home for youth aged 15-21, operated by Threshold Housing Society by investigating how harm reduction practices are conducted in the context of youth addiction recovery. A second focus of this study is to understand the role that informal learning opportunities play in addiction treatment at SRP.

Importance of this Research:

Harm reduction is a well-established approach used in addiction treatment, primarily focusing on minimizing the negative consequences of substance use without necessarily requiring immediate abstinence. However, there is a notable gap in the existing literature concerning the application of harm reduction specifically with young people. This study seeks to address this gap by investigating how harm reduction practices are conducted in the context of youth addiction recovery. More needs to be known about how it is done, the legal limits of practice, and the challenges of practicing harm reduction.

What is Involved for You:

Doug Magnuson and/or Lewis Rhodes will be reading your daily logs about harm reduction interventions in response to resident substance use. Occasionally we may have questions about your entries, and we will approach you informally during your shift or by email. No information about your identity will be collected. We will also be counting the frequency of these interventions for each resident.

Inconvenience:

There will be extra time needed to enter information about harm reduction practices at the end of each shift. We anticipate 5-10 minutes per shift.

Risks:

There are no known or anticipated risks to you by participating in this research.

Benefits:

There is no specific concrete benefit to you. Eventually we hope these analyses will be helpful to you and to SRP for considering how this work is done.

Voluntary Participation:

Your participation is voluntary, in part and in whole. You may decline to let us collect any of your logs or you may ask us not to collect data about a specific incident. Consent is ongoing, and you may withdraw your permission at any time.

Anonymity:

No identifying information about you or residents will be collected, published, or shared. We will not reveal the status of your participation to the managers of Threshold.

Confidentiality:

Data will be accessed by us through a secure connection to a SharePoint folder. Information about you and your practice that could be used to identify you will not be used.

Dissemination of Results:

Lewis will be writing his master's thesis using this data, and Doug and Lewis are hoping to write an academic paper for publication. These will be shared with you and with Threshold staff.

Disposal of Data:

We would like to keep this data for two years after collection on the UVic server. Then it will be deleted.

Contacts:

You may contact Doug Magnuson or Lewis Rhodes at the email addresses in the first paragraph. You can also reach Doug by text or phone [redacted] and Lewis by text or phone [redacted].

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545) or (ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

_____	_____	_____
Name of Staff	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix C: International Conference on the Prevention of Youth Homelessness Slides

Harm Reduction Recovery for Youth (HRRY): An Innovative Solution to Youth Homelessness

Kacie Stirrett, Threshold Housing Society

&

Lewis Rhodes, University of Victoria

International Conference on the Prevention of Youth Homelessness 2025

Feb 24, 2025

THRESHOLD HOUSING SOCIETY

Presentation Outline

- Introduction to us!
- Overview of Threshold Housing Society's youth Supportive Recovery Program
- Overview of UVic research project
- The Harm Reduction Recovery for Youth Model (HRRY)
- Questions

Overview of SRP

- Threshold Housing Society
  - Founded in 1990 in Victoria, BC
  - **Mission:** Prevent adult homelessness by providing safe housing, support services, and community to at-risk youth.
  - **Vision:** A community where all youth thrive
- Supportive Recovery Program (SRP)
  - Live in recovery program
  - Fully funded by Health Authority
  - Ages 15-21
  - Focusing on recovery, harm reduction, and housing-first principles
    - Integrated case management and recovery programming
    - Wrap around services during slips instead of discharge
    - Discharge to housing not houselessness

Foundations of SRP

Youth Autonomy

Recovery and Harm Reduction

Unconditional Positive Regard

Relentless Engagement

Dead Kids Don't Recover

Why Research SRP?

How we started?

Gap in Relevant Research

Harm Reduction + Recovery + Youth = Does not exist

Ethical grey areas

Primarily focused on abstinence only approaches.

The Goals

Understand what "doing harm reduction" looks like in practice at SRP;

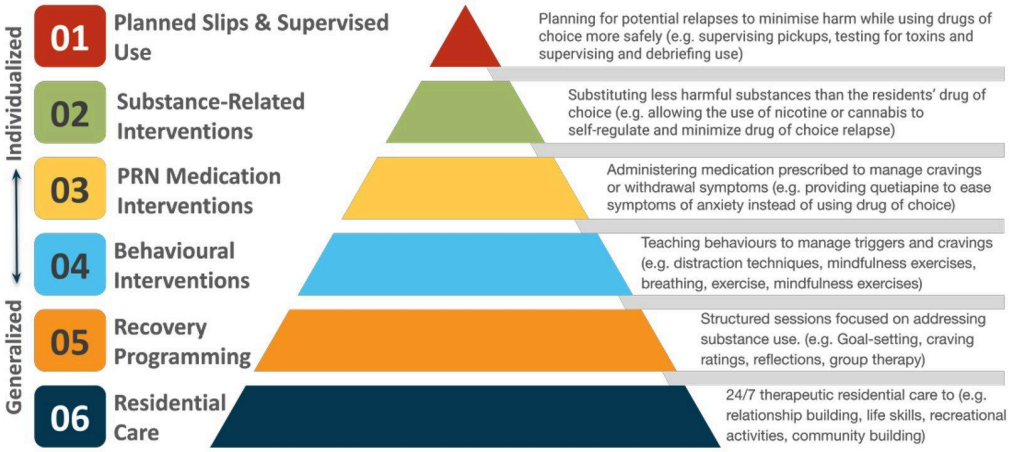
What are the interventions that matter from a staff perspective?

Method

Qualitative Interviews with SRP staff

Quantitative Data Collection

Harm Reduction Recovery for Youth (HRRY)



Residential Care

The Foundation for Change:

- "The opposite of addiction is connection"
- Building trauma-informed and youth-centred therapeutic relationships between staff and residents to establish trust and inform care
- Daily interactions and relationship building with a focus on undoing shame and stigma helps prevent crises and reduce triggers.
- Individualized approaches are essential to a harm-reduction recovery interventions

Recovery Programming

Empowering Youth Through Structured Programs

- Formal Programming
  - Reflection & Mindfulness Group
  - Goals Group
  - Recovery Group
  - Physical Education
  - Evening Activities

Behavioural Interventions

Stress Management and Trigger Reduction & Prevention

- Short-term and long-term coping strategies (e.g. Mindfulness exercises, breathing techniques, positive reinforcement)
- Stress Management and Trigger Reduction
- Emphasizes developing internal coping strategies

PRN Medication Interventions

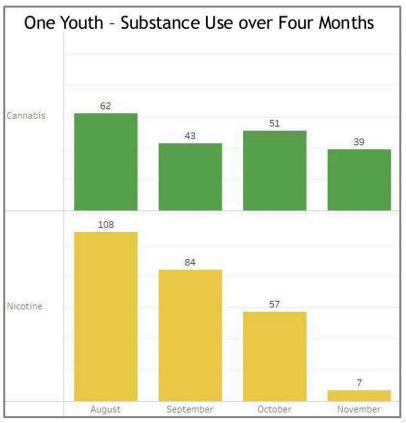
Supporting Youth in Managing Withdrawal and Cravings

- PRN ("as-needed") medications administered by staff in coordination with medical professionals
- Medication monitoring and adjustments as necessary
- Personalized withdrawal management plans that integrate safer substance use strategies when necessary.
- Youth can remain on prescribed safer supply and OAT.

Substance-Related Interventions

Guidance on Safer Substance Use

- Recognizes that many youth are not seeking recovery supports for some substances
- Cannabis & Tobacco as Harm Reduction Coping Strategies, i.e. smoking/vaping instead of using drug of choice
- Focus on harm reduction
  - Safe, supervised consumption
  - Rules around frequency and dosages to help youth establish boundaries around use



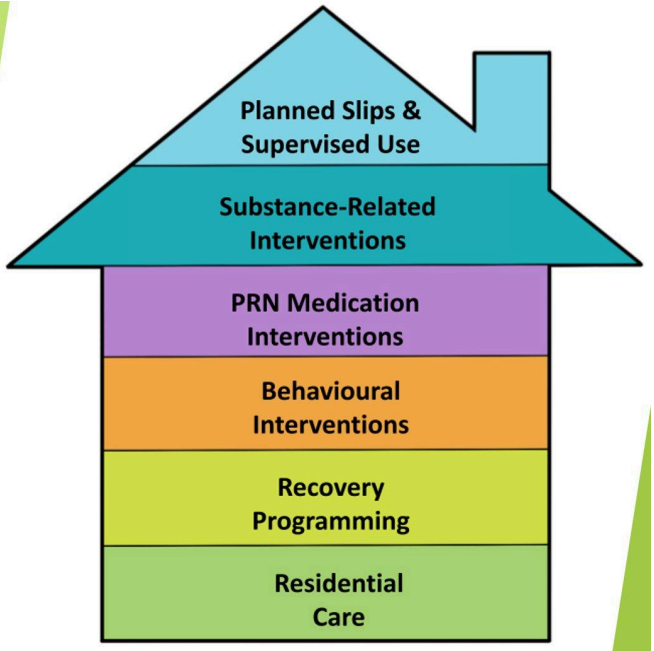
Planned Slips & Supervised Use

Managing Relapses Without Punishment

- Structured relapse prevention plans from day one
- Relapse is part of recovery
  - Relapse does not equal failure
  - It's a crucial learning opportunity
  - It's an opportunity for connection instead of disconnection
- Dead Kids Don't Recover
  - Staff will provide supervised consumption when necessary to reduce risk
  - Staff provide guidance on managing "planned slips" safely while maintaining program engagement

What are the benefits?

- Keep youth "in the house"
  - Prevents youth from cycling back into homelessness and directly interrupts the trajectory into adult homelessness
- Promotes autonomy, while reducing long-term substance use harms
- Improved recovery rates
- Successful transitions into stable housing
- Personalized, flexible approaches enable long-term engagement in recovery



Closing Thoughts

Key Takeaways

- Harm Reduction and Housing-First principles are essential tools in supporting youth facing homelessness and substance use challenges
- Harm Reduction Recovery expands recovery services to a harder to reach demographic
- A tiered intervention framework provides adaptable & scalable support and enables youth to experience success even without abstinence
- **Dead Kids Don't Recover!**

Next Steps

- Replicating SRP's HRRY model in other communities
- Continued research to expand harm reduction best practices
- Continued advocacy to keep these programs available to youth