

Harm Reduction on Campus Toolkit

CENTRE FOR INNOVATION IN CAMPUS MENTAL HEALTH

Canadian Mental Health Association Ontario

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How to use This Toolkit

This toolkit is intended for campus staff, faculty, and administrators who would like to know more about harm reduction approaches, the realms that it can be applied to, and specific practices for specific instances on post-secondary institutions.

The goal of this toolkit is to **provide awareness, education, and recommendations** to equip Ontario post-secondary campuses when it comes to supporting students who may be engaging in high-risk behaviours.

We recommend using this toolkit in a way that makes sense for the reader's needs. If you're looking for a specific topic, please use the landing page at campusmentalhealth.com/toolkits/harm-reduction-on-campus to select your topic of interest or browse the index. You're welcome to print the full toolkit or any section you need. The reflection sheet with questions at the end of the toolkit is available for you to print if you would like to jot down any thoughts on the topics we have covered.

If you are interested in recommendations and campus spotlights, you will find them at the end of each section. Unfortunately, not all sections will have a campus spotlight. If you have any questions or feedback regarding these recommendations or campus spotlights, you can email the project lead Tarin Karunagoda at **tkarunagoda@campusmenathealth.ca** or **info@campusmentalhealth.ca**.

Disclaimer

This toolkit is not intended to be entirely comprehensive; rather, it offers an introduction for those who have little to no familiarity with harm reduction principles and/or practices. It is meant for educational purposes and does not intend to promote certain modalities over others. This toolkit is not intended to admonish or judge higher-risk behaviours or put certain harm reduction practices above others.

The authors have attempted to ensure most practices and research are within the relevant contexts but would like to acknowledge that the vast literature related to harm reduction tends to focus on substance use.

We want to also acknowledge that this toolkit uses research largely based on Eurocentric and Western worldviews. There are important cross-cultural discussions related to the application of harm reduction that are beyond the scope of this toolkit but merit further attention and reflection.

Positionality

This toolkit was created in collaborations with professionals and experts who have backgrounds in mental health, addictions and/or post-secondary sectors. The project lead, Tarin Karunagoda brings educational and professional perspectives on the neuroscience of addictions, post-secondary and youth mental health and harm reduction work within university settings.

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“Not only is it important to remind people that harm reduction is everything from wearing a seatbelt to offering supervised consumption sites, but research also shows that harm reduction often produces the strongest positive social and health outcomes both for individuals who use the services and for the communities they live in.”

Part I

Introduction to Harm Reduction

What is Harm Reduction?

Harm reduction is multiple things at once. It is a movement, a philosophical approach to relationship-building, and a set of concrete strategies that can help reduce the potential health and social harms of certain behaviours, including substance use, gambling, sex work, and more.

> *Notably utilized in the context of substance use and addictions, harm reduction is best known as a movement for social justice built on a belief in, and respect for, the rights of people who use drugs (National Harm Reduction Coalition [NHRC], 2020).*

As an interpersonal philosophy, harm reduction is an approach for building relationships of care and support—especially with people who use drugs or whose activities are otherwise marginalised, criminalised, and/or stigmatized (e.g. sex work). The core principles of harm reduction instruct us to meet others 'where they are at' with non-judgement, compassionate curiosity, and an understanding that people make choices for reasons that are often adaptive to their circumstances. That is, drug use and other potentially harmful behaviours often serve an important purpose for people.

Harm reduction is also a set of practical strategies about how to reduce the potentially negative or harmful consequences of certain behaviours without an expectation that the person abstains from those behaviours entirely. It is a "pragmatic yet compassionate set of principles and procedures" that recognizes that many people will continue to use drugs and engage in risky behaviours despite prevention efforts (Marlatt, 1996, p. 779). It also accepts that many people are unwilling or unable to seek and access treatment, and that others may not need treatment but would still benefit from harm reduction practices.

A harm reduction approach prioritizes education—about harms and potential options to reduce or eliminate them—and a respect for a person's autonomy. In this framework, people are encouraged to set their own goals for health and wellness and are supported in taking "any steps in the right direction" to meet them (Logan & Marlatt, 2010, p. 201).

Finally, harm reduction emphasizes the need to address and focus on specific vulnerabilities among marginalized groups, recognizing that harm is often concentrated based on social determinants of health (income, racial background, gender and sexual identity, immigration status, and so on).

Principles of Harm Reduction

The following principles, developed by the US-based National Harm Reduction Coalition, summarize what a harm reduction approach entails in supporting people who use unregulated drugs but can equally be applied to other potentially risky behaviours as well as the use of regulated substances. These principles inform structural and systems-level work, as well as interpersonal engagement.

Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them

Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others

Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies

Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm

Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them

Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use

Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm

Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use

(NHRC, 2020)

At the person-to-person level, these key principles can also be distilled as:

- **Humanism**
- **Pragmatism**
- **Individualism**
- **Autonomy**
- **Incrementalism**
- **Accountability without termination of the relationship.**

Definitions of these principles are included below; although borrowed from research in healthcare settings, they are applicable to campus settings (Hawk et al., 2017). Concrete suggestions for supporting people based on these principles are offered in subsequent sections.

PRINCIPLE	DEFINITION
Humanism	• Value, care for, respect, and dignify people as individuals • Recognize that people do things for a reason; harmful health behaviours provide some benefit to the individual and those benefits must be assessed and acknowledged to understand the balance between harms and benefits
Pragmatism	• None of us will ever achieve perfect health behaviours • Health behaviours and the ability to change them are influenced by social and community norms; behaviours do not occur within a vacuum

PRINCIPLE	DEFINITION
Individualism	• Every person presents with his/her/their own needs and strengths • People present with spectrums of harm and receptivity and therefore require a spectrum of support options
Autonomy	• Though we can offer suggestions and education regarding students' support options, individuals ultimately make their own choices about medications, treatment, and health behaviours to the best of their abilities, beliefs, and priorities
Incrementalism	• Any positive change is a step toward improved health, and positive change can take years • It is important to understand and plan for backward movements
Accountability without termination (healthcare settings)	• Clients are responsible for their choices and health behaviours • Clients are not "fired" for not achieving goals • Individuals have the right to make harmful health decisions, and providers can still help them to understand that the consequences are their own

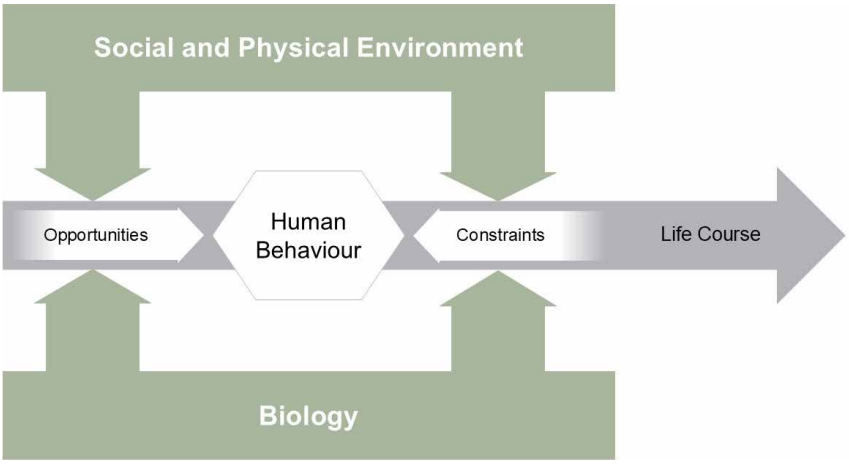
REFLECTION:

Within your own practice or role, how might you apply harm reduction principles when supporting students?

Understanding Substance Use & Potentially Harmful Behaviours

In an excellent guide to understanding substance use from a health promotion perspective, the authors write,

> *Human experience is complex. Helping people understand that complexity, and giving them skills to manage it, helps make them actors (rather than victims) in their own lives. That said, no one is completely autonomous. Our choices and behaviours are influenced by a variety of factors, including biology, physical and social environments and events throughout our life course (Here to Help, 2013, p. 2).*



(Here to Help, 2013, p. 2)

The diagram above shows how our social and physical environment, as well as our personal biology (including genetics), influence the opportunities and constraints of our lives. In turn, these opportunities and constraints affect our behaviour across our life course.

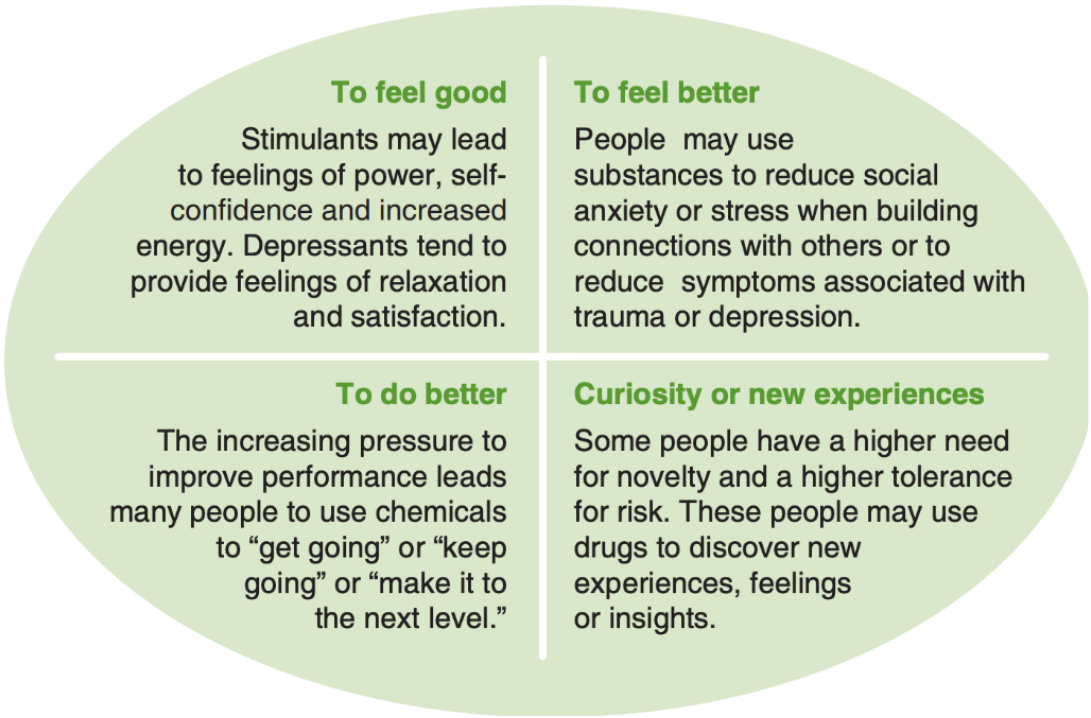
The full guide can be accessed here:
Understanding Substance Use: A Health Promotion Perspective

One important element of behaviour formation in relation to substances and potentially harmful behaviours (e.g., gambling, compulsive relationship with sex/porn, shopping) is the role of the brain reward system. Brain systems involved with feeling pleasure and reward help reinforce behaviours that feel good or primitively, that are needed to survive. This reward system helps us feel satisfaction when we eat, have social interactions, exercise, or have sex by releasing the chemical dopamine. When levels of dopamine are elevated, we feel a sense of pleasure and reward that help reinforce these behaviours. Many substances, gambling, pornography, binge eating, video games, and more, are associated with the release of dopamine (Avena & Bocarsly, 2012; Bello & Hajnal, 2010; Linnet, 2020; Love et al., 2015; Nutt et al., 2015).

This video provides an explanation of how the brain reward system works and changes when people use substances: ***How an Addicted Brain Works***

If the frequency or intensity with which we pursue dopamine-releasing experiences increases, our brain's dopamine receptors become less sensitive, and we develop tolerance to that stimulation. While this is certainly not the only process that contributes to behaviour formation, it is a very important one. Indeed, there is conflicting evidence on whether certain substances lead to significant increases in the release of dopamine (Nutt et al., 2015). Moreover, a person's individual genetic and biological makeup, as well as their social and environmental contexts will mediate how the physiological experience of dopamine-release impacts behaviour, preferences, choices, and priorities.

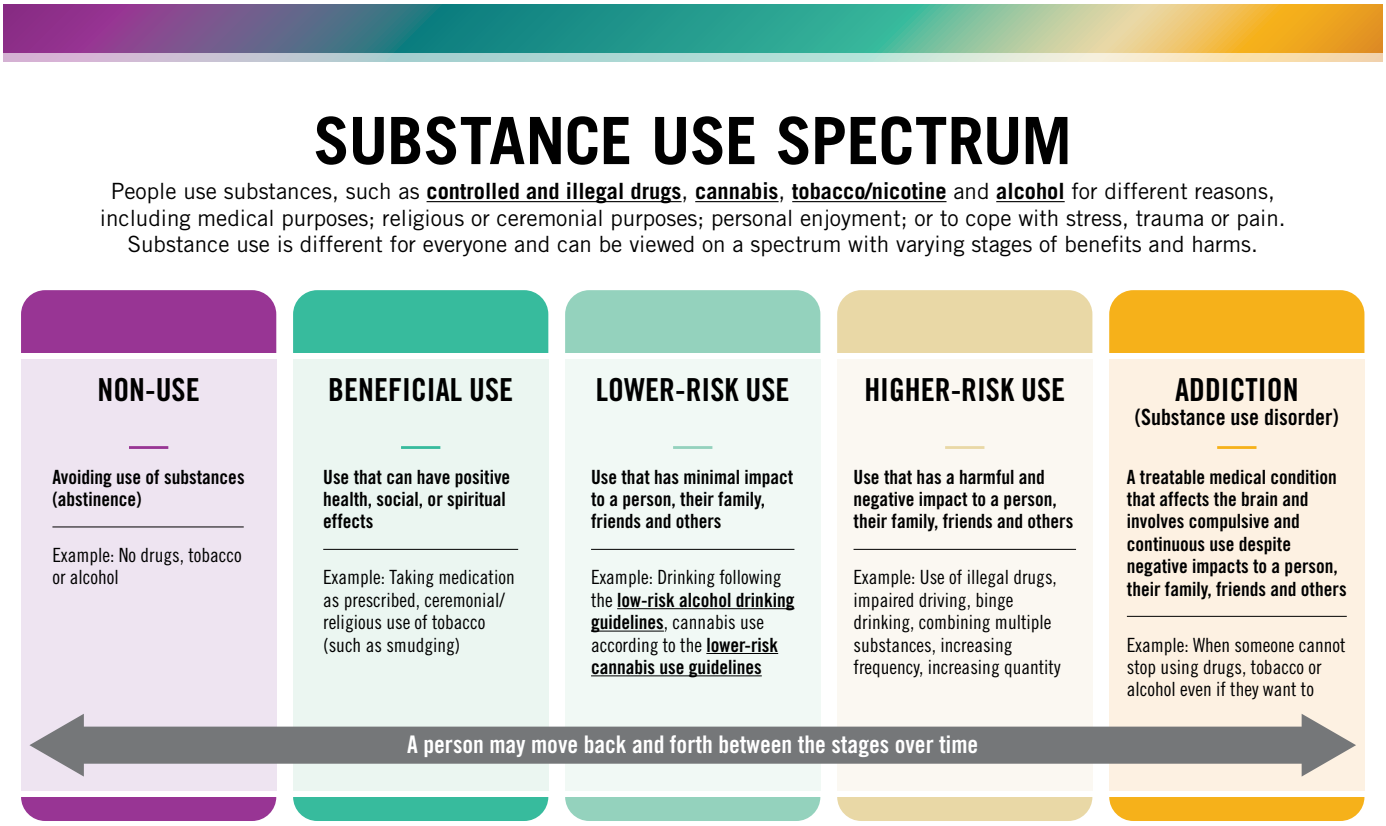
Thus, it is important to understand from an individual's perspective *why* they are engaging in a particular behaviour—beyond the potential 'feel good' experience of having elevated dopamine levels in their brain. The image below summarizes the reasons that people may engage in substance use. However, these reasons can apply to other potentially harmful behaviours as well.



(Here to Help, 2013, p. 3)

Continuum of Substance Use & Potentially Harmful Behaviours

Whatever a person's reasons, using substances or engaging in a potentially harmful behaviour exists on a spectrum of benefit and harm. Health Canada's depiction of this spectrum is included below. On one end, there is non-use (or non-engagement in potentially risky behaviour). Subsequently, there is beneficial use, followed by lower-risk use, higher-risk use, and addiction (in medical contexts, addictions are referred to as substance use disorders).



(Health Canada, 2022)

People can move along this continuum over their lifetime, and most substance use, or potentially harmful behaviour does not necessarily lead to addiction. Just as a person's biology, genetics, and social and environmental contexts affect their reasons for engaging in a potentially harmful behaviour or using substances, these factors also impact how vulnerable a person is to the risks associated with that choice. In other words, two people could engage in the same behaviour and face dramatic differences in outcomes. This will be the focus of the following section.

For those who do end up developing an addiction, it can be characterized by four key elements: **Craving**, loss of **Control** of amount or frequency of use, **Compulsion** to use, and use despite **Consequences** (The Centre for Addiction and Mental Health [CAMH], n.d.-a).

Risk Factors & Barriers to Accessing Care

Post-secondary students are not at equal risk of the potential harms associated with substance use or risky behaviours. This section addresses the factors that make certain students more, or less, vulnerable to harms as well as the potential barriers that students face in accessing care.

Social Determinants of Health

Social Determinants of Health
Non-medical factors that influence health outcomes

Health Inequities
Systematic differences in the health status of different population groups

As discussed, there are multiple factors that impact a person's relationship with substances or potentially harmful behaviours. In addition to our own personal biology, genetics, and choices, there are social determinants of health that influence our well-being. In short, **social determinants of health** are "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (World Health Organization [WHO], n.d.). Examples include income and social status, employment and working conditions, education and literacy, physical environments, race, gender, and sexual orientation (Public Health Agency of Canada [PHAC], 2024a). Social determinants of health largely operate at the systemic and structural levels and are impacted by the policies, norms, and systems that determine the social distribution of wealth, power, and resources.

They affect everyone, but not in the same ways. Therefore, there can be clear distinctions in health status between certain individuals and groups that emerge over time. Systematic differences in the health status of different groups are referred to as health inequities.

Research shows that, in many cases, social determinants of health can be more important than healthcare and lifestyle choices in influencing health. Below are a few examples of how the social determinants of health produce inequitable population-level health outcomes in Canada:

- Increased rates of substance use, depression, anxiety, self-harm, and suicidal ideation among Indigenous youth is associated with intergenerational and contemporary trauma, including the impacts of colonialism, the residential school system, systemic racism, and poverty (Hop Wo et al., 2020; Nutton & Fast, 2015; Spillane et al., 2023)

- Socioeconomic marginalization, measured through housing, employment status, education, criminal justice system involvement, and more, is strongly associated with being at risk for experiencing an opioid-related overdose (van Draanen et al., 2020)

- Discrimination is linked to chronic disease and other negative health outcomes. In a survey of University of Toronto students, racialized students had around 2.5x higher odds of experiencing poor general health outcomes in comparison to white students (Banerjee et al., 2022; Siddiqi et al., 2017)

REFLECTION:
How can we support students who are disproportionately affected by social determinants of health?

Risk & Protective Factors

Students face diverse life circumstances that can serve as risk and protective factors for harmful substance use or risky behaviour. How one person responds to these factors will differ based on their unique situation and personal biology. There is evidence that genetics play some role in making some people more vulnerable to developing an addiction, but they do not definitively predict it (Hatoum et al., 2022; 2023). Both life stress and traumatic stress are associated with increased substance use and/or risky behaviour (Broman, 2005). This can include:

- Financial stress – poverty or income instability, debt, loss of a job (Price, 2022)

- Academic stress – graduation, failing a class, increased course load, transitions (Pascoe et al., 2019)

- Social stress – trying to fit in, feeling lonely, family conflict (Strickland & Acuff, 2023)

- Minority stress – minority groups experience stress stemming from experiences of identity-based stigma and discrimination (Felner et al., 2020)

- Child abuse, victimization, oppression, intergenerational trauma (Moustafa et al., 2021; Tang et al., 2024)

- Accidents and injuries, especially those that lead to disability, including chronic pain (Hartz et al., 2022; Hoffman et al., 2024)

- War, conflict, violence

People who struggle with their substance use or other risky behaviours often also experience concurrent mental health conditions, including depression, anxiety, obsessive compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), and more (Substance Abuse and Mental Health Administration, 2024). It is estimated that more than 20% of people with mental health conditions have a co-occurring substance use disorder (Rush et al., 2008). The number may be as high as 50% for people with schizophrenia (Buckley et al., 2009).

Another risk factor for youth substance use or risky behaviour is being a part of social environments where drug use or compulsive behaviours are encouraged or normalized, especially at a young age by peers or caretakers. Attitudes related to drugs, gambling, shopping, pornography, and more are disseminated through social media, popular media, and peer networks.

Compulsive behaviour within the context of addictions refer to repetitive and potentially uncontrollable behaviour that occurs despite negative consequences (Heinz., et al, 2024).

Conversely, there are several protective factors that can reduce the likelihood of harm related to substance use or risky behaviours (Cannabis Health Evaluation and Research Partnership [CHERP], 2024). They function at several levels:

- **Individual** – healthy coping skills for emotional regulation and stress management; positive self-image and high self-esteem; help-seeking behaviour when in need of support
- **Family** – warm, supportive family of origin that meets basic physiological and emotional needs, including developmentally-appropriate supervision
- **School** – supportive and reliable adult relationships; peer connections that promote pro-social behaviour and norms
- **Community** – regular opportunities for leisure and play; youth programs and infrastructure, including mental health services, that are accessible

Intersectionality

An intersectional approach is one that considers how a person's multiple, overlapping identities interact to create unique experiences of privilege or oppression (Crenshaw, 1991). People who use drugs or who participate in criminalized or stigmatized activities "are often part of multiple minority groups, compounding the effect of their identities on their experiences and increasing the likelihood that they will experience oppression in systems" (Irvin, 2024, para. 1). Thus, when we interrogate the role of a social determinant of health or risk factor in promoting certain outcomes, it is important to consider intersectionality.

For example, although the criminalization of drugs affects all of society–because people who use drugs exist in virtually all communities–it impacts certain groups more negatively than others. Due to a history of systemic anti-Black racism and an over-policing of their communities, Black people are significantly over-represented in Ontario correctional facilities and have historically been arrested at disproportionately high rates for drug possession (Khenti, 2014; Owusu-Bempah et al., 2023). This does not reflect any meaningful differences in the rates of substance use between racial groups; rather, it highlights the differential impact that the 'war on drugs' has on different groups (Lopez, 2015).

Indigenous Harm Reduction

> *Before it was ever called harm reduction, Indigenous, Black and other people of color were figuring out the most effective and culturally responsive ways to keep their communities healthy and safe in the face of racism, colonialism, and historical trauma (NHRC, n.d.-a, p. 9).*

Indigenous harm reduction is a process of incorporating cultural knowledge and values into the services and strategies of harm reduction (First Nations Health Authority, [FNHA], n.d.). Although approaches to Indigenous harm reduction are varied and diverse, they are grounded within Indigenous worldviews as well as generally centre an understanding of the impacts of colonialism and intergenerational trauma. Indigenous harm reduction can take a **decolonizing** perspective, focusing not only on individuals but also on the systemic and structural forces that constrain their lives, including colonialism. A decolonial approach to harm reduction attempts to return power and control to people from whom it has been systematically removed, prioritizes community-based and peer-led programs, is trauma-informed, creates culturally safe interventions, and is reflexive. Harm reduction is **Indigenized** when interventions or programs are culturally grounded, strengths-based, and Indigenous-led (Canadian Aboriginal AIDS Network & Interagency Coalition on AIDS and Development [CAAN & ICAD], 2019).

"Indigenizing harm reduction is similar but different from decolonizing harm reduction. Decolonizing policies or programs is an attempt to deconstruct or dismantle existing policies and programs that are rooted in colonial thinking, while Indigenizing policies and programs is about building something new that is grounded in Indigenous ways of knowing" (CAAN & ICAD, 2019, p. 12).

An example of Indigenous harm reduction principles, developed by the First Nations Health Authority, is included below.

THE PRINCIPLES AND PRACTICES USE CULTURAL REPRESENTATION FROM FOUR PROMINENT ANIMALS HERE IN BC. EACH ANIMAL IS REPRESENTED BY SYMBOLISM, A HEALING PRINCIPLE, AND COMPARATIVE HARM REDUCTION STRATEGIES:



THE WOLF

- A symbol of relationships and care.
- Healing requires working together as one heart and one mind.
- This representation is associated with harm reduction principles that emphasize the importance of building relationships with people who use substances. An example of carrying out this work might look like providing outreach services.



THE EAGLE

- A symbol of knowledge and wisdom.
- Healing requires time, patience, and reflection.
- This means acknowledging that wellness is a journey instead of a destination. It aligns with the harm reduction principle that support may take many ongoing opportunities. It also means that in our professional work practice we take the time to reflect on our own emotions and allow room for patience in our engagements with people who are using substances.



THE BEAR

- A symbol of strength and protection.
- Healing is embedded in culture and tradition.
- This principle celebrates a strength-based approach in working with harm reduction. This also recognizes culture and tradition as intergenerational strengths that are methods of harm reduction on their own.



THE RAVEN

- A symbol of identity and transformation.
- Healing requires knowing who you are and accepting who you were.
- This healing principle acknowledges that the path to wellness is a journey that encompasses the exploration of identity and that mistakes will be made along the way. We do not need to carry the burdens of past, as they transform us when we learn from them.

(FNHA, n.d.)

Further resources on Indigenous harm reduction can be found here:

Indigenous Centred Approaches to Harm Reduction and Hepatitis C Programs by Canadian AIDS Treatment Information Exchange (CATIE)
Indigenous Harm Reduction by FNHA

Barriers to Accessing Care

There are many reasons why people do not or cannot seek the care they need when struggling with addiction. Stigma against people who use drugs or have addictions is prevalent and represents a significant barrier to accessing care. It both keeps people from reaching out when they need help and sometimes shapes their experiences with healthcare providers, who can perpetuate discriminatory attitudes.

The Pain of Stigma: Recognizing Stigma and its Impacts
by the Canadian Centre on Substance Use and Addiction (CCSUA)

Racism, transphobia, homophobia, sexism, and other forms of discrimination—whether implicit or explicit—further limit the accessibility of many services, including harm reduction programs. As such, mental health services tend to have the lowest utilization rates among racialized students (Lipson et al., 2022; Wildey et al., 2024). As harm reduction work has become increasingly institutionalized, workers tend to be mostly white and programming lacks input from and representation of diverse communities. Peer-led programs that address the specific needs of particular groups (e.g., women's drop-in, BIPOC support group) are one way of addressing these barriers.

Overarching Recommendations for Harm Reduction on Campus

- Adopt a whole campus approach when educating, creating programs, and implementing policies related to harm reduction.
    - Education and collaboration should not be limited to health services, but include residence staff, library staff, janitors, campus police, etc. This ensures greater capacity building.

- Ensure harm reduction practices are informed with EDIAA, trauma informed, and anti-oppressive lenses.
    - This approach accounts for intersectionality within a diverse community of students. It strives for all students to feel supported and continue to feel safe in seeking supports and existing within campus as they are. For instance, promoting inclusive languages and practices that do not further stigmatize the student or ensuring considerations for the needs of neurodiverse students.

- Embed harm reduction principles within different levels of services and stages of student life to prevent harms, support students experiencing harms, and caring for students after harmful experiences.
    - Different periods may include orientation week, exam periods, holidays, and post-graduation
    - Different services may mean during health promotion, peer-support, or counselling
    - Adopt a “Good Samaritan” policy that encourage reporting of emergencies without fear of punitive repercussions

- Center student voice and work in collaboration when determining the supports they would like to see (See our **Student Engagement Toolkit** and **Engagement & Co-design** webinar)

    - Utilize peer-based supports especially within equity deserving groups that may feel less comfortable seeking support or deal with greater amounts of stigma

    - Use student voices and students with lived experiences to inform programs on campus and continuously evolve with their feedback. This also helps with being informed on current trends, whether it pertains to technology, social media, or substance use.

- Create partnerships with community organizations and utilize their services to build capacity when supporting students



Part II

Substance Use on Campuses

The life period that someone first initiates substance use or risky behaviour varies, but many people begin to experiment notably in high school, and during post-secondary years. Trends in recent drug use among Ontario students in grades 7-12 include an increase in nonmedical use of prescription opioids from 13% in 2021 to 22% in 2023 (Boak & Hamilton, 2024). The use of alcohol, nicotine (smoking and vaping), and cannabis are somewhat common among high school students, with age of first use for these substances averaging around 15 (Boak & Hamilton, 2024; Holligan et al., 2019; Stewart et al., 2022). Students are more commonly exposed to unregulated substances in later years as they enter post-secondary environments.

While most students remain relatively safe when they consume substances or engage in potentially risky behaviours, there are nevertheless important negative impacts on individuals, campus, and surrounding communities. Results from the 2021-22 Canadian Post-Secondary Education Alcohol and Drug Use survey show the most recent information regarding student substance use patterns (Health Canada, 2024).

ALCOHOL	CANNABIS	OPIOID, STIMULANT OR SEDATIVE
• 45% of students stated that they drank heavily in the past 30 days. • Among those who drank, almost half of the students experienced at least 1 alcohol related harm in the past month. • 40% of the students said that their alcohol consumption stayed the same with the onset of the COVID-19 pandemic, while 30% consumed more.	• 64% experienced harms related to cannabis use. • Alcohol was the top choice of substance used with Cannabis among students. • Cannabis use increased among 47% of students with the onset of the pandemic.	• 13% of students had used a substance (pain reliever, stimulant, etc) in a high risk manner in the past year. • 12% used illegal substances such as cocaine and heroine. • 2% of students smoked daily. • 8% vaped daily.

The survey also found reported rates of overall alcohol and cannabis use to have decreased compared to 2019-20. Nevertheless, students reported greater use of alcohol and cannabis if their mental health was poor compared to those with good mental health since the COVID-19 pandemic. Additionally, the Canadian Tobacco and Nicotine Survey reported stress reduction and curiosity as primary reasons for vaping among youth of post-secondary age, while those who were 25 years and older used it for smoking cessation (Health Canada, 2023).

Drug Toxicity Crisis

Starting in 2016, Canada saw a rapid increase in opioid-related overdose deaths. This crisis is one of a toxic and highly volatile unregulated drug supply. Stigma, criminalization, and lack of access to robust supports and services have contributed to the crisis. With the intended closure of many supervised consumption sites across the Ontario province by March 31, 2025, there are additional concerns with supporting people who use drugs to be safe and connected with care (Casey, 2024).

The number of Ontario youth dying from overdose has been rapidly increasing. Among those aged 15-24, the number of opioid-related deaths increased by 47% in the first year of the COVID-19 pandemic and since 2014, opioid-related death rates for Ontario teens and young adults have tripled (Akbar et al., 2024).

Canada Opioid Crisis: How You Can Help *By CCSUA*

Substances

The primary focus of this toolkit is to extend the principles and practices of harm reduction beyond substance use, given that there are several excellent resources dedicated specifically to drugs and alcohol. This section offers a brief overview of the main substance classes being used by students and resources for reducing substance use related harms.

It is important to note that there are overlaps between these substance groups, and that the effects one experiences by combining them will be distinct from those experienced when a single type of substance is consumed. The effect of any psychoactive drug is impacted by the mindset of the person taking the substance (‘set’), the environment they are in (‘setting’), and the dose.

CATEGORY	EXAMPLES & NAMES	EFFECTS
Depressants	Alcohol (Paton, 2005) GHB Benzodiazepines (e.g., Xanax, Valium)	• Acts like a sedative and mild anaesthetic • Can produce feelings of pleasure, relaxation, disinhibition, nausea, vomiting, and/or impairment of motor functions • Alcohol is linked with aggression • Withdrawal can be fatal and must be medically supervised, symptoms can include nausea, tremors, vomiting, extreme irritability, anxiety, hallucinations, and seizures • Can contribute to respiratory depression when used in combination with other substances (e.g., opioids)
Cannabinoids	Cannabis, including synthetic weed, pot, marijuana (NIDA, 2024)	• Can produce feelings of calm, hunger, dry mouth, levity, arousal, lethargy, drowsiness, anxiety, paranoia • Intoxicating effects of Cannabis are associated with a compound called tetrahydrocannabinol (THC) while the non-intoxicating effects are associated with cannabidiol (CBD) • THC can result in a “high” that alters perception of time and affects memory, thinking, and motor skills • Adolescents who use cannabis are at higher risk of developing psychotic disorders (McDonald et al., 2024) • Smoking or vaping cannabis causes harm to the lungs • Frequent and high cannabis use has been linked to deficits in attention, memory, learning, and language

CATEGORY	EXAMPLES & NAMES	EFFECTS
Stimulants (ADF, 2024)	Cocaine Caffeine Amphetamines (e.g., Adderall) Methamphetamines (e.g., crystal meth) Nicotine	• Have an intense activating effect on the brain, making people feel more energetic, confident, and alert • Increase energy and euphoric feelings but reduce appetite • An overdose on stimulants is often called 'overamping' and can lead to heart attack, stroke, seizure or overheating (NHRC, n.d.-b) o Physical symptoms might include nausea/ vomiting, tremors, teeth grinding, chest pain, convulsions, and accelerated heart rate o Psychological symptoms might include anxiety, panic, paranoia, hallucinations, extreme agitation, and aggressiveness
Opioids (Johns Hopkins Medicine, n.d.)	Heroin (dope, smack) Fentanyl (fetty, fent) Oxycodone Codeine Morphine Methadone	• Effects include pain relief, relaxation, euphoria, drowsiness, nausea, and constipation • Opioids suppress breathing and can lead to overdose, respiratory arrest, and death • Depending on the person, dependence, tolerance, and opioid use disorder can develop, with dangerous and life-threatening consequences
Hallucinogens/ Psychedelics	Psylocibin (magic mushrooms) LSD (acid) DMT MDMA (ecstasy, molly, M)*	• Can contribute to heightened senses, visual or auditory hallucinations, distorted perception, euphoria, spiritual connection, loss of coordination, unusual behaviour, anxiety, panic, psychosis • Have lower dependence potential • *MDMA has both stimulant and hallucinogenic properties

CATEGORY	EXAMPLES & NAMES	EFFECTS
Dissociatives	Ketamine (special K, ket) Nitrous oxide PCP	• Can produce feelings of relaxation, weightlessness, euphoria, disconnectedness, numbness, hallucinations, panic, loss of motor skills, blurred sense of own identity • Dissociatives are considered a class of psychedelic drugs



The Drugs Wheel *by CATIE*
provides a visual summary of substance categories, examples, and effects

REFLECTION:
Does this toolkit bring up any feels or attitudes towards substance use or harm reduction? Where do they come from? Do you think they might contribute to stigma?

Outcomes of Harm Reduction Approaches with Substance Use

Due to its highly politicized nature, there are many misconceptions related to harm reduction programs and a lack of knowledge about their outcomes. Common beliefs held about harm reduction include that these types of programs promote or 'enable' substance use, contribute to community disorder, and increase crime rates. Not only is it important to remind people that harm reduction is everything from wearing a seatbelt to offering supervised consumption sites, but research also shows that harm reduction often produces the strongest positive social and health outcomes both for individuals who use the services *and* for the communities they live in. For example:

- Between 2018 and 2023, police data indicates a notable reduction in crimes such as robberies, break and enters, theft, shootings, and homicide in neighbourhoods that had supervised drug consumption sites in Toronto compared to neighbourhoods that didn't have one (Woodward, 2024)

- Methadone maintenance therapy has shown to improve social functioning, reduce risk-based behaviours, improve physical and mental health, and reduce mortality among people who use opioids (Beirness et al., 2008)

- Overdoses occurring in public are 10 times more likely to result in hospital admission than those occurring at supervised consumption sites. Hospital admission is a much costlier intervention (Canadian Mental Health Association [CMHA], 2018)

Recommendations

In general, campuses should develop a whole campus approach related to substance use that attempts to integrate harm reduction principles and practices into all levels of programming, services, and student life. Specific interventions will vary based on location and student body needs, but can be wide ranging:

- Deliver health promotion and education on prevention, destigmatization, and reducing harms with substance use
    - For example, encouraging testing substances, not using unknown substances, ways to mitigate aftereffects, and responsible consumption.
    - Understand the intricate nature of substance use dependency and its overlaps with other mental health conditions.
    - Embed harm reduction into curriculum for students in front-line work-related programs (Estreet et al., 2017).
- Provide programs and initiatives that are accessible for students:
    - Accessible – students are aware, and programs are culturally safe and confidential.
    - Easy access to rooms and locations to sober up, increased transportation services during certain events such as homecoming, St Patrick's day, or Halloween, access to water and snacks, and peer support.
    - Make Naloxone and harm reduction supplies widely available.
- Encourage a culture of community and safety
    - Train students and staff in being an active bystander, naloxone training, CPR (cardiopulmonary resuscitation), and identifying overdoses.
    - Training on overdose response and harm reduction should be a mandatory part of orientation, including residential orientation.
    - Providing safe and confidential ways to report.

- Providing judgement free supports and reducing harmful language surrounding substance use. An allyship tip sheet can be found **here.**

- Invest in peer-led stigma reduction campaigns, support, recovery, and harm reduction programs that are located on-campus.

Resources to Promote Substance Use Harm Reduction

Educational materials should cater to students and reach them on the platforms they use (e.g., TikTok, Instagram, Snapchat). For example, **End Overdose** makes their **Naloxone training, drug testing**, and **overdose response** videos available on multiple platforms.

Other ideas for interventions, programs, and strategies can be found in the many in-depth harm reduction guides and toolkits for substance use developed by universities and health organizations. They include:

- **Low-Risk Alcohol Drinking Guidelines** and the **Lower-Risk Cannabis Use Guidelines** outline some harm reduction approaches to consuming alcohol and cannabis.

- **Harm Reduction: A Guide for Campus Communities by University of Victoria**

- **Safer Drug Use: A Harm Reduction Guide**

- **Twelve Characteristics of Client-Centred Supervised Consumption Services (SCS): A toolkit for service design, delivery and evaluation**

- **Harm Reduction Fundamentals: A toolkit for service providers**

- The US-based National Harm Reduction Coalition maintains a **library of resources, toolkits, and training materials** related to safer drug use

- **CICMH Reducing Cannabis Harms: A Guide for Ontario Campuses**

CICMH Webinars:

- Navigating Substance Use Issues and Recovery Supports in Post-secondary Institutions
- Harm Reduction with the Umbrella Project
- Managing Alcohol at Campus Events
- Cannabis Use Guidelines and Recommendations for Ontario's Campuses
- Opioid Overdose Prevention & Harm Reduction

Campus Spotlight

The Umbrella Project - Algonquin College

The Umbrella Project focuses on helping students reduce problematic effects, and provides training, workshops, awareness, and support services for students and employees, including a Harm Reduction Toolkit

Lancers Recover – University of Windsor

Lancer's Recover is a peer mentorship program that helps students interested in learning about or seeking recovery from substance use as well as problematic alcohol consumption. This is done through weekly recovery meetings, social events, community outreach, and more. You can also learn more from our CICMH webinar.

Peer Support Service – University of Toronto

As part of their peer support training, the Peer Supporters are trained and educated on Harm Reduction approaches pertaining to substance and alcohol use.

Alcohol Recovery Room – University of Guelph

The alcohol recovery room in an open and non-judgemental space provided for students to sober up after heavy drinking, specifically around events where there might be high alcohol consumption (e.g. Homecoming, St. Patrick's Day and Halloween). It provides six beds and is staffed with volunteers, nurses and addiction support workers to support students.

Behavioural Addictions

Behavioural addictions refer to addictions that are specific to certain behaviours or feelings that arise from acting out these behaviours (Alavi et al., 2012). Criteria for behavioural addictions include continuously failing to resist the impulse to act on the behaviour, increased tension before and feeling a lack of control during the behaviour and sense of relief when engaging in the behaviour (Goodman, 1990). Examples of behavioural addictions are gambling, compulsive sex, internet use, and gaming. We will outline each of them within this section.

Problematic Gambling

Gambling is a form of entertainment where betting games or lotteries are played for money or other prizes. Problem gambling occurs when a person reaches a point in gambling where its consequences, whether those be social, financial, or psychological, negatively affect the person and the people around them. A substantial proportion of harm is suffered by those individuals who fall below the clinical threshold for gambling disorders (Wardle et al., 2024).

Gambling can be incorporated into various forms of games, including sports betting, lotteries, raffle tickets, bingo, virtual or in-person slot machines, and scratch tickets. Some of the most common gambling activities among youth and young adults include online and sports gambling, scratch tickets, and playing the lottery (Boak & Hamilton, 2024; Hollén et al., 2020).

> *"Gambling among college students can lead to issues such as low grades, suicide, missed classes, physical violence, binge drinking, and mental health problems. Problem gambling is characterized by uncontrollable, destructive, and compulsive gambling with significant deleterious personal, social, financial, psychological, vocational, and academic consequences among college students" (Kapukotuwa et al., 2023, p. 2).*

Based on 2018 data, 65% of Canadians have engaged in some form of gambling in the past year (Rotermann & Gilmour, 2022). Of them, 1.6% reported moderate to severe risk of problems related to gambling. Some of their findings included:



While high quality data and evidence related to youth gambling is not consistently available, research demonstrates a few general trends.

- People younger than 25 have a higher rate of problem gambling compared to those who are older (CAMH, n.d.-b)
- The estimated lifetime prevalence of problem gambling among college students is approximately 5% (Kapukotuwa et al., 2023; Nowak, 2018)
- A large majority of people with gambling addictions are men, and most also suffer other mental health conditions (Erbas & Buchner, 2012)
- More access to legalized forms of gambling such as sports betting and e-gambling increases its prevalence. Proximity to casinos likewise increases gambling prevalence (Adams et al., 2007; Kapukotuwa et al., 2023)
- Student athlete status is found to be a predictor of problem gambling (Marcinkevics, 2020)
- Parental or family history of problem gambling increases risk (Nower et al., 2022)
- Online gambling can induce higher risk-taking behaviour and problem gambling (Mcbride & Derevensky, 2012)
- Students perceiving benefits from gambling is a predictor of problem gambling (Wickwire et al., 2007)
- Recent problem gambling is higher among students who use stimulants (Geisner et al., 2016)
- Higher risk among international students, specifically those who are male. (Thomas et al., 2012)
- Within post-secondary institutions, discussing gambling with students is a lower priority compared to discussing harms and best practices associated with alcohol and substance use. Only one third of Canadian universities had gambling-related policies according to a 2018 survey (Marchica et al., 2018)

Despite the potential harms, gambling is often enjoyed as a casual social activity and a person's involvement can range greatly. The diagram below depicts the spectrum of gambling behaviour.



- **NO GAMBLING:** This person does not partake in gambling
- **CASUAL SOCIAL GAMBLING:** Most people fall under this category, where they occasionally partake in gambling for entertainment (i.e., casinos, lottery tickets, raffles)
- **SERIOUS SOCIAL GAMBLING:** People who fall under this category find gambling as their main form of entertainment and partake in it during a large portion of their free time
- **HARMFUL INVOLVEMENT:** People who experience consequences in many areas of life (e.g., financial, relational, professional) due to their gambling
- **PROBLEM GAMBLING:** People who are experiencing harms in all areas of their life due to gambling and are unable to control their desire to gamble regardless of the negative consequences

People can show many different signs of problem gambling (CAMH, 2022). In extreme situations, it can lead to bankruptcy, legal issues, job loss, truancy and dropping out, and suicide. Other signs that precede these outcomes typically include:

- Gambling increasingly larger amounts and spending more and more time gambling
- Stopping doing things they previously enjoyed
- Prioritizing gambling over other social life, family, school, work, and self-care
- Changing patterns of sleep, eating or sex
- Having conflicts with other people over money
- Using alcohol or other drugs more often
- Gambling regardless of negative consequences
- Decreased mood and irritable behaviour when trying to stop
- Constantly thinking about gambling

REFLECTION: Does your post-secondary institution have specific policies pertaining to gambling and supporting students with gambling?

Harm Reduction and Gambling

Harm reduction strategies have more commonly been implemented and studied in land-based gambling (e.g., casinos) environments (Marionneau et al., 2023). A survey of more than 4,000 American students determined that harm reduction practices were protective for men as they showed lower scores for problem gambling and spent fewer dollars overall (Lostutter et al., 2014). Self-determination has also been shown to strongly reduce problem gambling behaviour in college students (Neighbors & Larimer, 2004).

Developed by the Canadian Centre on Substance Use and Addiction (CCSUA), the Lower-Risk Gambling Guidelines intend to help minimize the harms associated with gambling (CCSUA, 2021). These guidelines are meant to be considered holistically, rather than as distinct recommendations, and can be used with students to establish goals.

GUIDELINE 1 Amount of Money

Gamble the amount of money that is equivalent or less than 1% of your household income per month

GUIDELINE 2 Frequency of Gambling

Gambling no more than 4 times a month

GUIDELINE 3 Type of Games

Gambling at a maximum of 2 types of games

Other recommendations include:

- Providing awareness and education on early signs of problem gambling, financial literacy, safer gaming alternatives, and non-judgemental supports.
- Educating students on how online gambling is marketed to increase gambling, either through language (“Level up!”), promise of great fortune, and/or colourful visuals.
- Organize events that shift focus away from entertainment activities that involve winning money (sports, arts, social gatherings, etc.)
- Proactively offer professional support services specifically aimed at addressing student gambling, rather than it being an after-thought.

Resources

Learn more about guidelines here:

- ***Lower Risk Gambling Guidelines***

- ***Young Adults and Gambling*** *by Responsible Gambling Council (RGC) outlines risks specific to young adults, helpful resources, games and quizzes to educate young people on gambling.*
- *Access a sample* ***'Gambling Harm Reduction Recovery Plan'*** *Worksheet*

  Access other gambling-related resources from CICMH here:

  - ***Gambling and Gaming on Campus: A Hidden Problem? – Infosheet***
  - ***Gambling and Gaming on Campus: A Hidden Problem? – Webinar***
  - ***Problem Gambling in Post-Secondary – Webinar***
  - ***Gambling within Post-Secondary Institutions – Webinar***
  - ***Cannabis and Gambling Addiction Awareness - Podcast***

Compulsive Buying Behaviour

Compulsive buying behaviour (CBB) occurs when a person engages in repetitive excessive purchasing of items that, most of the time, are not used, and usually leads to significant financial consequences. Compulsive buyers experience craving before and at the moment of purchase but are regularly disappointed by the things they buy (Weinstein et al., 2016). CBB is highly correlated with childhood trauma and abuse, and is often motivated by feelings of low self-esteem, loneliness, depression, or anxiety (Elbarazi, 2023; Richardson et al., 2024). By some estimates, 80-95% of those affected are women (Black, 2001). Studies show that young adults, within post-secondary ages, have higher prevalence rates of CBB, and with the widespread availability of online shopping, at-home delivery, and glamorization of overconsumption, compulsive buying can be challenging to identify (Maraz et al., 2016).

People who struggle with CBB are likely also experiencing concurrent mental health challenges (Black, 2001). These can include:

- Depression
- Anxiety
- Attention Deficit Hyperactive Disorder (ADHD)
- Obsessive Compulsive Disorder (OCD)
- Borderline Personality Disorder (BPD)
- Substance use disorders
- Eating disorders

Generally, for compulsive buying to become a clinical concern, there must be personal dysfunction or distress within an individual's social, financial, and occupational life due to the purchasing behaviours. The dysfunction is less about the impact of the items themselves (although hoarding is an important co-occurring condition to be aware of) but the strong desire to buy, associated financial strain, and difficulty controlling these actions despite the impact. Attempts to suppress or control urges to compulsively shop can produce strong emotions that further contribute to the person's distress. Conversely, buying items may still elicit negative feelings such as anger, self-blame, shame, guilt, and embarrassment—thus leaving people feeling stuck in a destructive cycle (Elbarazi, 2023).

Signs of CBB include (Koran et al., 2006; Weinstein et al., 2016):

- Repetitive, irresistible, and overpowering urges to purchase goods that are frequently useless and/or unused
- Shopping for periods longer than necessary
- Experiencing impulses to shop in response to negative, challenging, or intense emotions
- Tendency to be secretive about purchases

Supporting students who are struggling with CBB should involve, whenever possible, clinical mental health providers. Although the evidence-base is thin and inconclusive with respect to psychotherapeutic or pharmacological evidence-based interventions, **group therapy** is a promising support service (Hague et al., 2016; Lourenço Leite et al., 2014). Other helpful individual strategies to reduce the harm of compulsive buying can include (Thomas et al., 2024):

- Setting a weekly or daily limit on spending
- Buying only with limited amounts of cash
- Leaving credit and debit cards at home
- Reducing 'buy now, pay later' options
- Developing financial literacy on topics such as credit card management, budgeting, and saving
- Tracking your finances or meeting with a financial advisor to keep track of spending patterns
- Reducing exposure to media that may show overconsumption or advertisements (e.g., shopping hauls on social media, promotion emails)
- Finding alternative activities to buying when feeling negative emotions
- Recognizing triggers and emotions that lead to impulse buying, especially during holiday seasons
- Developing emotion regulation strategies (e.g., mindfulness)

There is a need for specialized support related to compulsive buying specific to youth, as currently the primary support for this may be a mental health professional or a financial advisor.

Campus Spotlight

Dr. Sunghwan Yi, a University of Guelph professor who researches compulsive buying, uses his work to create tools such as online self-assessments in hopes to help people identify their buying patterns as well as any early signs of reduced control with their buying habits. You can learn more about his work ***here***.

REFLECTION:
How might culture, socioeconomic status and/or upbringing affect students' susceptibility to compulsive buying?

Problematic Internet Use (Gaming, Social Media)

Technology use (or internet use) is now widespread and is increasingly introduced to children at progressively younger ages. Nearly 36% Ontario youth in grades 7-12 use their cell phone for more than 5 hours every day and close to 20% have symptoms in line with moderate-to-serious problem technology use (Margetson et al., 2024). The COVID-19 pandemic has influenced the rise of technology use among post-secondary students, and thereby increasing problematic use (Gómez-Galán, 2021).

Prevalence of problematic cell phone and internet use in post-secondary students vary but compulsive use has showed to be associated with depression, anxiety, poor sleep quality, pain and strains in the body, and impacting academic performance (Candussi et al., 2023, Kil et al., 2021, Sánchez-Fernández et al, 2022). Problematic internet use can vary depending on the activities students partake, but have been greatly associated with general browsing, gaming, social media, online shopping, and pornography.

Predictive factors for problematic internet use are:

- Patterns of use
- Lifestyle
- Psychological factors

Risk factors among young people are as follows (Sánchez-Fernández et al, 2022, Skues et al., 2015):

- Increased time spent online
- Online gaming
- Negative affect
- Life stress
- Loneliness
- Impulsivity
- Poor sleep quality
- Depression
- ADHD
- Alcohol and drug use
- Cognitive issues

Recommendations to managing technology and internet usage can be found below.

REFLECTION: What are some ways campuses can provide opportunities and spaces for students to disconnect from the internet or technology?

Resources
Problem Technology Use *video by CAMH*
Social Media and Cellphone Addiction Infosheet *by CICMH*

Compulsive Sexual Behaviour

Compulsive sexual behaviour (CSB) (previously known as hypersexuality, sexual addiction, and out-of-control sexual behaviour) is when an individual experiences sexual impulse or urges that are repetitive, hard to control in intensity, and results in impairment or distress in different areas of life (personal, occupational, social, or familial) (Marchetti, 2023). An important distinction is that the distress is less so measured by the potential emotional experience of shame, but rather by the intensity of the urges and whether they impede day-to-day life.

CSB typically begins to develop in late adolescence or early adulthood (during the post-secondary period). In the United States, lifetime prevalence rate ranges from 3–6% (Kuzma & Black, 2008); however, there are not enough studies conducted on this subject to ascertain the true prevalence. Additionally, the taboo nature of the topic results in less people coming forward with behaviours that may align with CSB. Individuals with CSB most often turn to masturbation, pornography, cybersex, strip clubs, and sex with various partners (anonymous or otherwise) as ways to meet their needs (Derbyshire & Grant, 2015).

Some key characteristics of CSB include:

- Frequent sexual activity and continuance despite negative effects
- Feeling as if sexual behaviour and thoughts are uncontrollable
- Distress due to health (e.g., sexually transmitted disease, unwanted pregnancy, mental health), financial, professional, and/or social consequences

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It is important to note that high libido is not a definitive indicator of CSB. Having a sexual drive is akin to sleep and appetite: a natural part of life and living. Especially within post-secondary, students are entering a period where they may experiment with their sexuality and their reasons for doing so may vary.

There can be various reasons for individuals to engage in CSB and any "signs" must be assessed holistically, in relation to the individual's unique life experiences. For example, various degrees of impulsive and increased sexual behaviours can be associated with substance use, manic episodes, medical conditions such as brain tumours, as well as medications that increase dopamine (Fong, 2006).

Individuals who struggle with CSB are also likely to be struggling with substance use, anxiety, mood, and/or obsessive-compulsive disorders (Ballester-Arnal et al., 2020). Childhood sexual abuse can also be a risk factor (Slavin et al., 2020).

Some ways for supporting students if they struggle with CSB are as follows:

- Education on consent and safe sex practices such as condom use, sexually transmitted and blood borne infections (STBBI) screening, practices that minimize urinary tract infections and contraception options.
- Allocating a limited time to consume pornography or masturbate to minimize frequency.
- Allocating a budget if there are frequent visits to strip clubs, subscriptions to sexual websites, or accessing sex workers (whether in-person or virtual)
- Creating routines and social connections with peers, friends, and family to ensure support.
- Journalling or tracking CSB to understand its triggers, frequency, and circumstances.
- Minimizing the use of substances or alcohol.
- Psychosocial supports to provide structure, accountability, and community.

REFLECTION: What are some ways you can show students that you are a safe and non-judgemental person to talk to about topics like sex and porn? What boundaries may you have? (In terms of extent of support, topic discussion or level of comfort.)

Resources

- ***Sex and Love Addicts Anonymous Ontario***
- ***Sex Addicts Anonymous***
- ***Association of Sex Therapy in Ontario***
- ***Hypersexuality Community Resources*** *by CAMH*
- ***Problematic Porn Use Infosheet*** *by CICMH for students*

Sexual Health & Sex Work

The post-secondary period can involve many milestones, questions, and challenges in relation to one's sexual health and identity. This period may also entail experimentation and exploration as students find independence and immerse themselves in campus culture. Consequently, this is also a period of elevated risk.

The COVID-19 pandemic, along with the legalization of cannabis, has changed sexual health outcomes and the way that services are accessed. Data from the Public Health Agency of Canada (2024b) shows a 25% increase in first-time HIV diagnoses in 2022 over the previous year. In a 2024 national survey of Canadians aged 18-24, 24% of participants said they use condoms "all the time," compared to 53% who said they always used condoms in 2020 (Alberga, 2024). While some data indicates that rates of binge drinking and sexual activity while using substances remained stable between 2012 and 2021, the use of cannabis while having sex has increased (Cano et al., 2023). Use of cannabis alongside sex is a risk factor for acquiring a sexually transmitted infection (Haghir et al., 2018). Apart from STBBIs, risks related to sexual behaviour and health include unsafe sex work, unwanted pregnancy, and compulsive behaviours.

Most post-secondary institutions try to provide resources and education to support students during this time, especially when students are transitioning from high school to post-secondary. This includes sex education, access to contraceptives, and conversations on safe sex and consent, which all fall under harm reduction strategies (Sansone et al., 2022). However, there is more work to be done, especially in addressing topics that may be considered taboo.

Sexually Transmitted and Blood Borne Infections

STBBIs are infections transmitted through bodily fluids from sexual activity or through contact with infected blood. These infections include chlamydia, gonorrhoea, herpes, vaginal infections, human papillomavirus (HPV), human immunodeficiency virus (HIV), and more.

It is important for students to understand not just the symptoms of these infections, but the process of transmission, latent phases, and how diagnoses occur (Cassidy et al., 2015). According to a Canadian study, the odds of acquiring a STBBI increases when having four or more sexual partners, using cannabis in the past 30 days, engaging in anal intercourse, and never being tested for HIV (Haghir et al., 2018).

Recommendations

In addition to sexual health services, educational and awareness programs related to these topics, which include promoting safer sex practices, are important for mitigating these risks. Steps campuses can take include:

- Making information on and access to STBBI testing readily available
- Providing low-barrier access to safer sex equipment (e.g., condoms, lube, dental dams)
- Supporting open and non-judgemental dialogue about sexual health with students
- Understanding cultural barriers and taboos related to sexual health and developing culturally appropriate services
- Addressing stigma as well as the taboo nature of certain topics (e.g., sex work, porn use)
- Adopting a harm reduction, sex positive, perspective to sexual health education that positions healthy sex as somewhere in-between 'unbound pleasure' and 'restricted sexual safety' (Naisteter & Sitron, 2010)
- Supporting peer education and support programs (e.g., to increase condom use and HIV testing)

Resources

- ***A Guide to Discussing Sexual Health, Substance Use, and STBBIs*** *by the Canadian Public Health Association*
- ***Best Practices for Sexual Health Promotion and Clinical Care in College Health Settings*** *by the American College Health Association*
- ***PRIM3D: A Sexual Health Guide for Queer Trans Men and Trans Masculine and Non-Binary People*** *by PRIM3D*
- ***Tips for Communicating about Sexual Health*** *by American Sexual Health Association*

Sex Work

Data is limited on the number of post-secondary students engaging in sex work. What's clear is that it is a reality on campuses. Internationally, it is estimated that between 2–7% of students engage in some type of sex work, mostly for financial reasons and because it offers flexibility (Ernst et al., 2021). However, sex work can be dangerous if students are faced with few other options to support themselves financially (otherwise known as 'survival sex'). Student debt can play an important role in maintaining this pressure. Students are also at risk of exploitation and trafficking when they enter the sex work industry, especially international students (Brown & Buckner, 2021). Other demographics that are overrepresented in sex work are 2SLGBTQIA+ people and Indigenous people (Benoit & Shumka, 2021; CPHA, 2014).

Specific risks of sex work can include:

- Transmission of STBBIs
- Unwanted pregnancy
- Human trafficking
- Stalking
- Gender Based Violence
- Criminalization

Students may have a hard time disclosing if they are engaging in sex work due to stigma and discrimination. When using a harm reduction approach, it is important to include student sex work as a part of service design and delivery.

Recommendations

Just as with other potentially risky behaviours and substance use, student support should focus less on what the student does, and more on the reason why. Educating students on the risks associated with sex work and providing access to harm reduction services are essential (Rekart, 2005).

It is crucial for conversation and supports to be non-judgemental and non-ideological, where the primary focus is on the needs of the student and not diverging them from their choices.

***Sex Work and Harm Reduction Discourse: A Reflection* provides nuanced discussions on whether harm reduction is the right framework to be used when it comes to sex work. It is a great resource for anyone who may want to understand where sex work organizations position themselves when it comes to harm reduction frameworks.**

Some harm reduction practices associated with sex work are as follows (Rekart, 2005):

- Working with people who are trusted or with friends
- Using contraception and other safe sex practices diligently and not relying on customers to provide condoms, lube, etc.
- Learning self-defence such as knowing which areas of the body to attack
- Ensuring anonymity in virtual or in person settings by making sure there is no identifiable information available when offering services
- Sticking to a set price and time frame of the service
- Wear comfortable shoes that are appropriate for running
- Screening clients whenever possible for name, references, and other information

You can find more about these strategies in the resources below, as well as some ways to support students specifically in terms of sex work.

Resources

- ***Sex Work Harm Reduction*** *by Michael L. Rekart*
- ***Educating Universities: Understanding and Responding to Student Sex Workers*** *by Gaynor Trueman, Teela Sanders and Jessica Hyer Griffin*
- ***Sex Work Support and Resources*** *by George Brown College*
- ***Sex Work Resources and Guides*** *by Maggie's Toronto*

Self-Harm

Non-Suicidal Self-Injury (NSSI)

Self-harming behaviour is referred to clinically as “non-suicidal self-injury” (NSSI), which will be used interchangeably with “self-harm” in this section. It is defined as “repeated cutting, burning, hitting, rubbing, or otherwise inflicting damage to body tissue for non-socially sanctioned reasons, but not as a suicide attempt and does not include body manipulations (such as piercings or tattoos)” (Guerdjikova et al., 2014, p. 326).

Self-harm is a maladaptive coping strategy, and is often used to self-regulate distressing emotions, as a form of self-punishment, or as a means of resisting a potential suicide attempt (Klonsky & Muehlenkamp, 2007). Although students may engage in self-harming behaviours without suicidal intent, it should be noted that these behaviours can indicate a risk of suicide—which should be thoroughly assessed by a qualified mental health professional.

REFLECTION: Do you have any preconceived notions about self-harm? How might some self-harm practices fall under the radar?

The following findings from studies can factor into how students are supported when it comes to NSSI:

- Self-harm is commonly seen among 2SLGBTQIA+ students compared to their cisgender and straight peers (Reddy et al., 2016).
    - This disparity can be explained by the Minority Stress Theory, which posits that health inequities experienced by members of sexual minority populations are partly due to excess stress in the form of stigma and internalized shame, the expectation of discriminatory events, and structural oppression. Some respond to these conditions by using NSSI as a coping strategy (Reddy et al., 2016).
- NSSI also has high levels of comorbidity with other mental health conditions and diagnoses (Baetens et al., 2024).

- It is estimated that the lifetime prevalence rate of NSSI among post-secondary students is 23% (Swannell et al., 2014).

- Individuals may avoid seeking support due to social stigma, concerns that the behaviour could be interpreted as a suicide attempt and therefore lead to hospitalization or worry about potential fearful reactions from others like friends and family (Hasking et al., 2015).

Harm Reduction and Self-Harm

A harm reduction approach to NSSI is not an endorsement or encouragement to self-harm. Rather, it accepts the difficult reality that some people are self-harming and that there are ways of minimizing the risks they consequently face, while simultaneously supporting them to address the underlying distress that is driving their behaviour. The goals of harm reduction in relation to NSSI are to have a person (Self Injury Support [SIS], n.d.-b):

- Prepare for self-harm, for example by having clean implements and first aid materials easily available

- Try to slow down the process to have as much control as possible

- Think about what wound or other care might be needed afterwards

- Try to keep what they do within limits that are safe to manage by themself

Harm reduction strategies are often used when taking a client-centered approach to NSSI, as these tactics can keep the client safe from suicide attempts or be used to cope with significant emotional dysregulation or crisis (Inckle, 2011; Klonsky & Muehlenkamp, 2007). Although there is limited research directly studying harm reduction as applied to NSSI behaviours, it is often used in conjunction with other therapeutic tools to “meet the client where they are” in recovery (Guerdjikova et al., 2014; Inckle, 2011). While the goal with clinical treatment is likely to eventually stop self-harm entirely, it is important to recognize that many individuals do not feel prepared to remove a coping mechanism that has been effective for them, and smaller steps may be required to make progress towards their goals.

To support someone who is self-harming, it is essential to understand the functionality of self-harm behaviours to that person (Guerdjikova et al., 2014; McKenzie & Gross, 2014). Building a repertoire of alternatives to self-harm, improving coping skills, and specialized therapy focused on emotional regulation and distress tolerance are important interventions to offer. Harm reduction-based alternatives to self-harming behaviours can include (SIS, n.d.-b):

- Delaying self-harm by developing awareness of triggers

- Creating a ‘safe space’ with no tools for self-harm to go/sit when urges arise

- Keeping tools for self-harm in awkward/hard-to-reach places
    - For example, the '15 minutes rule' ***tool*** helps delay and reduce self-harm
- Developing awareness of how and where self-harm occurs to reduce risks
    - Small steps can include using clean equipment, reducing the length of time, making a smaller injury, or cutting away from major blood vessels and arteries
- Distract or displace the urge to self-harm, for instance by holding an ice cube in the hand or on the wrist (SIS, n.d.-a)

Harm reduction should also include planning for aftercare, including seeking medical attention if the injury is significant. If a student presents at a mental health appointment with significant injuries, they should be directed to the appropriate resource for triage and medical care (i.e. Student Health Services, the Emergency Department).

Recommendations

- ✔ Making information for crisis resources, local urgent care, or emergency departments readily available for students if they require after-hours support.
    - This is particularly important for student-staff leadership positions and peer support programming where other students may be a first point of self-disclosure of NSSI (Baetens et al., 2024).
- ✔ Providing comprehensive training on responding to disclosures of self-harm to social stigma, encourage compassionate peer relationships, awareness of the scope and support limitations in order to direct students to the most appropriate and effective resources. (e.g. local and national crisis lines, which can be provided to students if they require after-hours support.)
- ✔ Campuses should invest in peer-led, but professionally supported, groups and campaigns (Abou Seif et al., 2022).
- ✔ Staff and faculty should be equipped to respond compassionately, validate the student's experience, and inquire about the student's overall wellbeing and support network (Baetens et al., 2024).
- ✔ Front-line staff should be well-versed in the signs and symptoms of self-harm and be proficient in screening for potential thoughts of suicide.

They should also be familiar with assessing readiness for change, applying harm reduction techniques that are student-focused (and grounded in suicide risk assessment), as well as trauma-informed, evidence-based treatment of emotional dysregulation and skill building strategies.

Resources

How to support someone who has disclosed self-harm to you, including possible questions and responses:

- ***Young People Who Self-Harm: A Guide for School Staff*** *by University of Oxford*
- ***Someone Has Told You They're Self-Harming. Now What?*** *By Dr. Stephen Lewis*
- ***Trauma-Informed Care for People who Self-Injure*** *by California Centre of Excellence for Trauma Informed Care*

Other resources that may benefit students:

- ***#chatsafe: A Young Person's Guide to Communicating Safely Online about Self-Harm and Suicide***
- ***Emotional Regulation Infosheet*** *by CICMH*

Resources specific to clinical staff:

- ***Clinician's Guide for the Management of Self-Injurious Thoughts and Behaviours*** *by CAMH*

Eating Disorders

For many, eating disorder behaviours can be considered a form of non-suicidal self-injury (Washburn et al., 2023). Although there are important criticisms of using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as the basis for understanding eating disorders, it is important to understand how the medical field categorizes them. The DSM-5 includes anorexia nervosa (AN), binge eating disorder (BED) and bulimia nervosa (BN) (APA, 2013). The table below provides a brief overview of the symptoms of each disorder:

DIAGNOSIS	SYMPTOMS
Anorexia Nervosa	Restriction of calories, intense fear of weight gain, distortions of one's view of self and the seriousness of their condition
Binge Eating Disorder	Recurrent episodes of binge eating, lack of control when eating, eating until uncomfortably full within a short period of time
Bulimia Nervosa	Episodes of bingeing followed by compensatory behaviours, which can include the use of laxatives, intense exercise, or purging to "compensate" for the food consumed

Surveys distributed to students attending 41 Canadian post-secondary institutions indicated that 2.6% of respondents were diagnosed with an eating disorder in the last year, specifically anorexia nervosa or bulimia nervosa (American College Health Association [ACHA], 2016). Given a low survey response rate in this study, the number might be higher; other data suggests it might be as high as 5% in universities (Stuckless, 2023). Furthermore, much of this data precedes the COVID-19 pandemic, which likely had a significant impact on the development and maintenance of eating disorders due to its effects on food prices, income security, and general mental health, especially since these societal stressors have continued into the present day (Barry et al., 2021).

There are many important factors to consider when addressing eating disorders on post-secondary campuses, including (but not limited to): the experiences of student athletes (notably in weight- or size-based sports that depend on the maintenance of a specific body type), the impact of financial stressors and food security, as well as the availability and accessibility of specialized eating disorder services (Barry et al., 2021; Bianchi et al., 2021; Byrom et al., 2022). Many post-secondary students face financial difficulties, impacting their access to nutritional food or specialized private care, subsequently contributing to the development and maintenance of disordered eating (Barry et al., 2021).

Terms to Know - Orthorexia and Anorexia Athletica

The term "orthorexia" is used to describe a cluster of behaviours focused on eating foods that are considered "healthy" or "natural", with little flexibility. Additionally, the term "anorexia athletica" has been used informally to describe a preoccupation with exercise as a method for maintaining or losing weight. Neither of these are clinical terms per se but are nevertheless used to describe specific disordered eating behaviours — especially for those working within post-secondary mental health services who may encounter these terms when working with their clients (NEDIC, n.d.).

Harm Reduction and Eating Disorders

Treatment for eating disorders can vary widely and is typically informed by the severity of the illness and accompanying behaviours. This can include, but is not limited to, counselling, groups (including peer support), residential support, outpatient support through specialized hospital programs, and intensive inpatient treatment (National Eating Disorder Information Centre [NEDIC], n.d.). Harm reduction can be integrated at all stages of treatment, and those who have attempted multiple intensive treatments with little success may benefit from a harm reduction approach, which promotes quality of life and client choice (Westmoreland & Mehler, 2016). However, there can be significant risk involved with this approach, and it should be addressed with care, expertise, and if needed, bioethics consultation (Bianchi et al., 2021; Westmoreland & Mehler, 2016).

There is very little empirical evidence available studying harm reduction approaches to eating disorders. Because of the potential lethality of eating disorders, there are complex ethical considerations to conducting research, including assessing consent and the potential impact of eating disorders on cognition (Bianchi et al., 2021). Anorexia specifically has the highest mortality rates of all psychiatric diagnoses (Auger et al., 2021). Eating disorders should therefore be approached with the support of qualified and specialized mental health professionals, potentially including regular medical monitoring or the involvement of an interdisciplinary health team (Bianchi et al., 2021). Harm reduction practices within the context of eating disorders, is therefore, not the end goal, but may be part of the recovery process depending on severity and capacity.

***Harm Reduction for Eating Disorders* webinar hosted by The Victorian Centre of Excellence in Eating Disorders discusses when and where harm reduction approaches are applied within the context of treating people with eating disorders.**

Just about any strategy for self-compassion can help reduce the harm of disordered eating (CMHA, 2022). These can include:

- For **Anorexia** -- use nutritional supplements (Boost, Ensure) to meet basic nutritional needs; aim for longer stretches between periods of fasting
- For **Bulimia** - aim for longer stretches between periods of binging or purging; get regular dental check ups
- For **Binge Eating Disorder** - keep high risk binge foods out of the house; consume sweets/treats only after a healthy meal

- **For any eating disorder or disordered eating**
    - Explore non-abstinence recovery goals
    - Focus on quality of life and not on the eating disorder
    - Avoid or limit use of social media
    - Distraction; engage in fun activities/ hobbies to keep distracted from thinking about food or body
    - Allow eating disorders behaviours at specified times
    - Explore options for things that can be within reasonable control
    - Remove scales from the home or limit weighing opportunities
    - Build a healthy network of friends, colleagues, neighbours
    - Seek out counselling or supports to deal with stress or life experiences (e.g., trauma, abuse, relationships, etc)
    - Avoid emotionally intense discussions during meals
    - Get creative about activities at mealtime (e.g., theme nights, games) and avoid conflict or watching the news
    - Take a cooking class or learn to cook for the joy in the activity and not for the eating
    - Go for regular medical check ups

Resources

- ***Harm Reduction is for Eating Disorders too*** *(includes a table of harm reduction strategies and tips)*
- ***Harm Reduction and Eating Disorders*** *webinar hosted by Sheena's Place*
- ***Diet Culture within Post-Secondary Settings*** *webinar by CICMH*
- *Eating Disorders on Campus Toolkit by CICMH*

REFLECTION: How might standards of beauty that is perpetuated by colonialism and white supremacy influence eating disorders and disordered eating?

Conclusion

Harm reduction approaches to address substance use and potentially harmful behaviours can be beneficial for a vulnerable population such as the post-secondary demographic. It champions students right for self-determination and minimize harms in a reliable manner. It can also provide an opportunity for trust and judgement free allyship to those struggling to reach out for support. While this toolkit is not exhaustive, we hope that it has shed some light on some topics that may be relevant to student mental health and wellbeing on campus. We have summarized key recommendations from the toolkit below.

Key Recommendations

- Adopt a whole campus approach when educating, creating programs, and implementing policies related to harm reduction.
- Ensure harm reduction practices are informed with an EDIAA, trauma-informed, culturally safe and anti-oppressive lenses.
- Embed harm reduction principles within different levels of services and stages of student life to prevent harms, support students experiencing harms, and care for students after harmful experiences.
- Center student voices and work in collaboration when determining the supports they would like to see.
- Create partnerships with community organizations and utilize their services to build capacity when supporting students.
- Deliver health promotion and education on prevention, destigmatization, and reducing harms with substance use.
- Provide programs, supplies, and initiatives that are easy to access and anonymous for students.
- Encourage a culture of community and safety on campus where students look out for each other.
- Provide safe and confidential ways to report potentially harmful or stigmatized behaviours without fear of repercussions.

- Invest in peer-led support, recovery, and harm reduction programs that are located on-campus.
- Harm reduction approaches around sexual health, sex work and compulsive sexual behaviour must be rooted in non-judgmental lenses, free of ideologies and moralities.
- In the context of NSSI (self-harm or eating disorders), harm reduction approaches must be utilized in conjunction to supports provided by mental health professionals.
- Reducing harms for behavioural addictions often may include creating productive routines, boundaries, financial literacy, and finding alternatives.
- There is a strong need for specific campus programs and initiatives to educate and support students pertaining to behavioural addictions and NSSI.
- Harm reduction practices can be utilized in the prevention of harmful behaviours, minimize harms when partaking in a potentially harmful behaviour, and care after a harmful outcome.

Reflection Sheet

This page is a compilation of reflection questions that appear throughout this toolkit. We recommend reading the toolkit before proceeding to these questions, as they are specific to the topics that are discussed. You can print/download and write your reflections to each of these questions based on your professional and personal experiences to better understand how harm reduction can play a role in your work.

1 Within your own practice or role, how might you apply harm reduction principles when supporting students?

2 How can we support students who are disproportionately affected by social determinants of health?

3 Does this toolkit bring up any feels or attitudes towards substance use or harm reduction? Where do they come from? Do you think they might contribute to stigma?

4 Does your post-secondary institution have specific policies pertaining to gambling and supporting students with gambling?

5 How might culture, socioeconomic status, and/or upbringing affect students' susceptibility to compulsive buying?

6 What are some ways your post-secondary institution can provide opportunities and spaces for students to disconnect from the internet or technology?

7 What are some ways you can show students that you are a safe and non-judgemental person to talk to about topics like sex and porn? What boundaries may you have? (In terms of extent of support, topic discussion or level of comfort.)

8 Do you have any preconceived notions about self-harm? How might some self-harm practices fall under the radar?

9 How might standards of beauty that is perpetuated by colonialism and white supremacy influence eating disorders and disordered eating?

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