

Harm reduction for stimulant use

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The harm reduction response to stimulant use remains underdeveloped compared to the harm reduction response to opioid use. This is despite rising prevalence of stimulant use in North America, Asia and sub-Saharan Africa; an end to the long-term decline in stimulant use in Western Europe; and high prevalence of use of cocaine and its derivatives in Latin America and the Caribbean.

A range of new harm reduction interventions have emerged over recent years to address harms associated with stimulant use.



Needle and syringe programmes

Unsafe injection of stimulants is associated with the transmission of blood-borne diseases, making it vital that people who inject stimulants have access to sterile injecting equipment.

Needle and syringe programmes are often perceived to be focused on people who inject opioids, which can be less inclusive for people who inject stimulants from attending.

The higher frequency of injection associated with injecting stimulants compared with opioids has crucial implications for NSPs for people who inject stimulants. The higher number of injections per day creates an increased risk of blood-borne disease transmission; and means that people need access to a greater number of sterile needles and syringes. This means NSPs must be resourced and willing to provide large numbers of needles and syringes at once.

Injection practices specific to stimulants also require NSPs to adapt. For example, needle gauge and syringe/barrel size preference can vary between substances, as does the need for specific filters. Wheel filters have a greater capacity for removing bacteria and adulterants, and are particularly valuable to people using home-baked methamphetamine. However, they are prohibitively expensive for people to purchase privately.

The anaesthetising effect of some stimulants on the injection site can lead to a greater risk of injury during subsequent injections. Butterfly needles – needles attached to flexible tubing that tolerates movement – allow people to use the same site for multiple injections, and therefore can ameliorate this risk.

Methamphetamines are the primary drug injected in Queensland, Australia. As such, NSPs in Queensland, Australia have distributed almost 500,000 butterfly sets since 2007, and services routinely provide several sizes of fixed-needle syringe and (in some cases) wheel filters.

RECOMMENDATION: Governments must support NSPs to be responsive and receptive to the needs of people who use stimulants. This might include removing caps on the number of needles distributed at a time, and providing specialised equipment such as wheel filters and butterfly needles.



Drug consumption rooms (DCRs)

DCRs are supervised health care facilities where people can use drugs in a safe and non-judgmental environment. DCRs support linkage to health and social services, and reduce morbidity and mortality by providing a safe space and training people on safer drug use. However, in some cases, access is restricted for people who smoke drugs or inject stimulants.

A challenge for DCRs permitting people to smoke substances, including stimulants, is passive smoking by service clients and staff. Best practices to address this include providing proper ventilation systems. Due to the high costs associated with ventilation, at least one DCR has met this challenge by allowing stimulant users to smoke on a balcony.

Providing separate rooms for people who inject and people who smoke drugs is also good practice as a strategy to prevent transition to injection. Watching and discussing injecting both can reduce inhibition against injecting. This should be implemented while not discouraging those who inject their heroin and smoke their stimulants, a practice which has positive harm reduction benefits for vein health.

Finally, stimulants have a strong surging effect that can make people animated and loud. This can be a different dynamic for DCRs to manage, and staff should be trained accordingly.

DCRs in Luxembourg, the Netherlands and Switzerland, all permit people to inhale drugs. In virtually all cases, smoking and injecting occur in different rooms within the facility, and smoking rooms are equipped with powerful ventilation. Most DCRs around the world permit the injection of stimulants.

RECOMMENDATION: Governments should support DCR facilities to permit and encourage the participation of people who use inject, inhale or smoke stimulants.



Safer smoking kits

The distribution of safer smoking kits (which can include glass stems, rubber mouthpieces, brass screens, lip balm and disinfectant wipes) aims to engage people who smoke drugs with harm reduction and health services and to reduce health complications caused by unsafe equipment. By using safer equipment, people who smoke drugs can avoid the emergence of lesions, burns and cuts to the lips and mouth that are associated with a risk of infection and hepatitis C transmission. It can also reduce the risk of lung issues associated with using improvised smoking equipment.

The use of improvised pipes made from plastic bottles or aluminium cans can lead to lung damage and the inhalation of carcinogenic fumes, and the practice of using a layer of cigarette ash to suspend the crack in improvised pipes is associated with emphysema. In some countries drug control regulations prevent the distribution of crack pipes. In these contexts, an alternative is to support street forms of glass-based improvised pipe and avoid the use of cigarette ash as a suspending agent.

Pipe distribution programmes can also encourage safer drug-taking practices. “Pin to pipe” programmes aim to encourage smoking rather than injection of substances, to avoid the greater risk of blood-borne virus transmission associated with injection. “Pin and pipe” programmes encourage people to administer different substances through different routes, to avoid “snowballing” (simultaneous injection of heroin and stimulant, most commonly cocaine, crack or methamphetamine).

Examples of programmes include Karisma in Indonesia, who distribute lighters, foil and straws, and COUNTERfit in Canada, who distributed 67,500 Pyrex stems in 2017. Both programmes employ peer workers in their outreach and pipe distribution services.

RECOMMENDATION: Governments must implement safer smoking kit programmes to ensure that people who smoke drugs have access to safe equipment.



Housing support

The provision of housing and other social support, without requiring abstinence from illicit drugs or enrolment in drug treatment, is an effective means of reducing harm. Housing and social support have the capacity to enhance stability in a person's life, which can help to reduce wider harms related to drug use. When providing housing to people who smoke stimulants, it is important that there are no penalties related to substance use – particularly smoking.

Atitude in Brazil and Housing First projects in Europe and North America are examples of the provision of stable housing as a harm reduction intervention, with no requirement that those housed abstain from drug use.

RECOMMENDATION: Governments and housing authorities must not restrict access to housing on the basis of drug use.



Drug checking

Stimulants are frequently used at nightclubs, festivals and parties. Drug-checking services aim to reduce the harm caused by high-purity and adulterated stimulants, by ensuring that people who use drugs understand some or all of the contents of the substance they plan to take.

They include on-site, walk-in and postal services. In many services, service users are obliged to take part in brief counselling sessions, during which they are given information and advice about harm reduction techniques.

Examples of this include on-site testing offered by Échele Cabeza in Colombia, and walk-in services in Bern and Zurich, Switzerland. Walk-in services in Switzerland have found that they attract a different population to on-site services, with people accessing the service more likely to be older and in precarious housing situations.

RECOMMENDATION: Governments should lift legal and regulatory barriers and put in place policy which supports the operation of drug-checking services.



Harm reduction in nightlife settings

In addition to drug checking, other interventions can address the harm of drug use in nightlife settings. These include providing chill-out spaces, hydration points, safer sniffing kits, and harm reduction advice and information. Some services also provide chewable sweets and fruit juice to prevent dehydration and damage to the mouth caused by teeth grinding.

For example, the GM ClubSafe Scheme in Manchester, United Kingdom was a partnership between venues, door staff, police and local government. The scheme encouraged venues to provide chill out areas, access to free water, first aid, and drug awareness training for bar and security staff. In return, clubs were able safely confiscate drugs. This reduced the routine involvement of the police, and provided information to health care providers and nightclub owners about the drugs in use.

RECOMMENDATION: Nightclub owners and festival organisers should provide low threshold harm reduction services, where possible with the co-operation of law enforcement.



Harm reduction for stimulant use in sexual contexts

The use of stimulants in sexual contexts, including among men who have sex with men, has been reported in Asia, North America, Oceania and Western Europe. The practice is commonly known as chemsex.¹ The use of stimulants, notably injected methamphetamine, in such circumstances is associated with an increased risk of HIV and hepatitis C transmission. Unfortunately, in most countries, services tailored to the needs of people using stimulants in sexual contexts are lacking.

An example of a service specifically tailored to the needs of men who have sex with men using stimulants in sexual contexts, are the PIP PAC “safer chemsex packs” are distributed by the Gay Men’s Health Collective in the United Kingdom. They include colour-coded injecting and equipment, condoms, hydration tablets and informational booklets.

RECOMMENDATION: Governments and harm reduction service providers must ensure that their services are accessible and tailored to the needs of people who use drugs in sexual contexts.



Substitution therapies

There is emerging evidence that substitution therapies² can be effective in reducing stimulant-related harm. Similar to opioid substitution programmes, these programmes encourage people who use stimulants to use another substance associated with fewer negative physical and social effects.

Projects in the Americas have explored the potential of substitution therapies using cannabis or coca leaves to address crack use, while elsewhere pharmaceutical products such as modafinil have been used to substitute both amphetamines and cocaine.

RECOMMENDATION: Governments must support rigorous research to understand the effectiveness of substitution therapies for stimulants.

Community mobilisation for harm reduction

Community groups, formal and informal networks of people who use drugs have been instrumental in pioneering groundbreaking interventions for people who use stimulants. In doing so, they have been able to provide essential, non-judgemental and specialised harm reduction services where formal services are lacking.

For example, the Urban Survivors Union in the United States and CounterFIT in Canada were instrumental in the early development of crack pipe distribution programmes. Similarly, the Crack Squad in the United Kingdom promoted improvised safer piping strategies, championed self-control strategies delivered through peer education sessions and created a training and development partnership with the Royal College of General Practitioners.

RECOMMENDATION: Governments and NGOs must support the development of networks of people who use drugs as vital partners in developing harm reduction interventions.

1. While the use of stimulants in sexual contexts is not limited to men who have sex with men, Adfam and the Gay Men’s Health Collective, define chemsex as “sexual activity between gay and bisexual men under the influence of specific drugs, usually methamphetamine, mephedrone and GHB/GBL.”

2. Sometimes known as pharmacotherapies.