SPEED LIMITS

HARM REDUCTION FOR PEOPLE WHO USE STIMULANTS

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Foreword

Harm reduction as a concept, being defined as "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (Harm Reduction International, 2018), has gained significantly in importance worldwide since the United Nations General Assembly Special Session (UNGASS) on the World Drug Problem in April 2016. This is reflected in an increased common understanding and commitment at the global, regional and national levels for health-oriented drug policies.

However, the concept of harm reduction is still widely understood as a strategy addressing injection drug use and the harms and risks associated with this route of administration. Harm reduction services for people who use stimulants (PWUS) are less common despite the constant rise in the prevalence of stimulant use at a global scale: The seizures of amphetamine-type-stimulants increased globally by 20 per cent in 2016, the latest available data. In the same period, the share of seized amphetamines rose by 35 per cent and the seizures of methamphetamine reached the record high of 158 tons, displaying an increase of 12 per cent. Cocaine has reached unprecedented levels of purity and availability on global markets with a 60 per cent rise in seizures since 2012, while also the cultivation of coca in South America has reached historical levels (UNODC 2018).

These worrisome developments require urgent responses by governments, civil society and international organizations - including in the field of harm reduction. One of the objectives of the Global Partnership on Drug Policies and Development (GPDPD), implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH on behalf of the Federal Ministry of Economic Cooperation and Development (BMZ), is seeking to enhance the evidence basis for development- and health-oriented drug policies.

In the light of the recent developments in global patterns of drug use, GPDPD has commissioned Mainline with a comparative study on existing evidence and case studies on harm reduction for stimulants, a still under-researched area of global drug policy for which there is a major international demand. The present two-fold study **"Speed Limits – Harm reduction for people who use stimulants"** significantly contributes to closing the gap of knowledge about which existing harm reduction interventions are effective for people who use stimulant drugs. It is the first study to comprehensively and systematically compile a literature review on various types of stimulants, routes of administration and harm reduction strategies, together with the presentation of different case studies at a global level, including regions of the Global South.

In its first part, the study broadly examines the existing research and literature on the issue in order to build the findings and recommendations on the state-of-the-art evidence on stimulant use and harm reduction strategies. The second part presents seven case studies from five continents, focusing on learning experiences and best practices from highly diverse interventions with varying legal, societal and cultural framework conditions.

The study clearly shows that the available research and evidence basis on stimulant use and appropriate harm reduction strategies is still weak. There is a clear need for more comparative research on this issue in order to address the current steep rise in stimulant use, to making sure it is properly addressed by evidence-based drug policies and available best practices of successful harm reduction strategies. We hope this groundbreaking study serves as a much-needed element in this process.

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Disclaimer:
This study reflects the combined results of a thorough literature review and the analyses and descriptions of seven cases of good practice harm reduction interventions for people who use stimulants in different world regions. The results do not necessarily reflect the positions of the German Federal Government.

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Glossary

3-MMC	3-Methylmethcathinone	DCR	Drug Consumption Room
4-MMC	4-Methylmethcathinone	DIC	Drop-In Centre
4-MEC	4-Methylethcathinone	DRA	Dopamine Releasers
ABD	Asociación Bienestar y Desarrollo (Spain)	DRI	Dopamine Reuptake Inhibitor
		EDS	Excited Delirium Syndrome
ADHD	Attention Deficit Hyperactivity Disorder	EMCDDA	European Monitoring Centre of Drugs and Drug Addiction
AIDS	Acquired Immuno Deficiency Syndrome	ENA	National strategy on addictions (Spain)
ATS	Amphetamine Type Stimulants	FACT	Flexible Assertive Community Treatment
BI	Brief Interventions		
BNN	National Narcotics Agency (Indonesia)	FGD	Focus Group Discussion
		GBL	Gamma-Butyrolactone
CAPSAD	Centres for Psychosocial Assistance on Alcohol and other Drugs (Brazil)	GHB	Gamma Hydroxybutyrate
		HBV	Hepatitis B Virus
CBD	Cannabidiol	HCV	Hepatitis C virus
CBT	Cognitive Behavioural Therapy	HIV	Human immunodeficiency virus
CCID	Central City Improvement District (South Africa)	ICW	International Community of Women Living with HIV
CDA	Central Drug Authority (South Africa)	IDPC	International Drug Policy Consortium
CM	Contingency Management	INPUD	International Network of People who Use Drugs
CRA	Community Reinforcement Approach		
		LBHM	Community Legal Aid Institute (Indonesia)
CRAS	Reference Centre for Social Work (Brazil)		
		LGBT	Lesbian Gay Bi-sexual and Transgender
CRAUDE	Reference Centres for Drug users (Brazil)		
		MBI	Mindfulness Based Intervention
CREAS	Specialised Reference Centre for Social Work (Brazil)	MDMA	Methylenedioxymethamphetamine
		MI	Motivational Interviewing
CRISM	Canadian Research Initiative in Substance Misuse	MIDES	Ministry of Social Development (Uruguay)
CTADS	Canadian Tobacco, Alcohol and Drugs Survey	MSM	Men who have Sex with Men

NDMP	National Drug Master Plan (South Africa)	SACENDU	South African Community Epidemiology Network of Drug Use
NGO	Non-governmental organisation	SACUDE	Municipal Complex of Health Culture and Sports (Uruguay)
NPS	New Psychoactive Substances	SCUC	Safer Crack Use Coalition (Canada)
NSP	Needle and Syringe Programmes	SRCHC	South Riverdale Community Health Centre (Canada)
OECD	Organisation for Economic Co-operation and Development	STD	Sexually Transmitted Disease
OSE	State Sanitation Work Organisation (Uruguay)	STI	Sexually Transmitted Infection
OSF	Open Society Foundation	SU	Service User
OST	Opiate Substitution Therapy	TB	Tuberculosis
OT	Occupational Therapy	UNAIDS	Joint United Nations Programme on HIV and AIDS
PKNI	Indonesian Drug Users Network (Indonesia)	UNODC	United Nations Office on Drugs and Crime
PLHIV	People Living with HIV	VWS	Ministry of Health, Welfare and Sports (Netherlands)
PTSD	Post Traumatic Stress Disorder	WHO	World Health Organization
PWID	People Who Inject Drugs		
PWUD	People Who Use Drugs		
PWUS	People who use stimulants		
RENADRO	National Network of Drug Care and Treatment (Uruguay)		

1 Introduction

Often when we think of harm reduction for people who use drugs (PWUD), we primarily think of HIV prevention among injection heroin users, for instance through needle and syringe programmes (NSP), HIV testing and treatment, and methadone treatment. However, harm reduction is much broader than that. The aim of harm reduction is to reduce all harms associated with drug use. These may be health harms, which certainly extend beyond HIV, but also include 'social or economic harms such as acquisitive crime, corruption, over-incarceration, violence, stigmatisation, marginalisation or harassment' (IDPC 2016).

Due to its underexposed nature, this study is solely directed at harm reduction for those who use illicit stimulants non-intravenously. This includes the swallowing, snorting, smoking and rectal administration (*booty-bumping*) of substances. As for the stimulants, these are specifically: amphetamine-type stimulants (ATS), cocaine and cathinones.

Interventions that address harms associated with stimulant use include substitution therapies, drug checking services, psychosocial support; condom, lubricant and drug paraphernalia distribution, accessible services for sexually transmitted infections, income generation support and job placement, housing, as well as the scale-up of services for people who inject stimulants. Peer-based models are an important mechanism to put harm reduction interventions into practice, especially for *out of hours* provision of services (IDPC 2016). Besides,

empowering people who inject drugs (PWID) to shift from injecting to other, safer routes of administration (such as snorting or smoking) is also seen as an important HR intervention (IDPC 2016). Since mar9ginalised (groups of) people who use stimulants (PWUS) often face a diverse range of social and health problems, ideally, harm reduction interventions should offer a 'multi-disciplinary and multi-speciality service' (Forum Droghe and Transnational Institute 2014).

1.1 Harm reduction in today's world

In recent years, several regions in the world have witnessed an increase in the use of stimulants. According to the World Drug Report 2018, amphetamine-type substances (ATS) are the second most commonly used illicit drug – after cannabis – with an estimated 34.2 million past-year users. The highest prevalence of ATS use is seen in North America and Oceania, and despite a lack of reliable data in Asia, methamphetamine use is seen as worrying in many countries in East and South-East Asia, and possibly also in West Asia (UNODC 2018b; EMCDDA 2018b). The emergence of synthetic stimulants, and primarily synthetic cathinones, presents additional challenges (UNODC 2018a, 2018b). Cocaine use, with an estimate of 18.2 million past-year users worldwide, also seems to be on the increase in some parts of the world. In Latin America, North America and the Caribbean, cocaine has had a long lasting presence (Gootenberg 2009), and remains the primary drug of concern, after cannabis, for

people seeking treatment in Latin America and the Caribbean (UNODC 2018b). In Europe, cocaine use seems to be resurging both in quantity and quality (purity) (EMCDDA 2018b).

This calls for a broadening of harm reduction measures and evidence for its effectiveness. Most innovative harm reduction practices are brought about by harm reduction organisations rooted in the field. They tend to have a deep knowledge of the context and the needs of people who use drugs. Many harm reduction programmes, however, omit the documentation of successes, despite some excellent practices in the field. Programmes the world over tend to be stand-alone projects, with few exemplary exceptions offering comprehensive integration of harm reduction in the healthcare systems. Not all countries offer harm reduction. In countries with more progressive drug policies, harm reduction is often integrated into national health and social services but in countries with stricter drug regulations, harm reduction projects often suffer structural lack of funding and/or political support. They tend to lack sustainability, a long-term perspective, and political commitment, being mostly financed by international donors. Few projects can survive political and financial changes, leaving people who use drugs in many countries the world over in dire circumstances. Better documentation of successful and innovative harm reduction practices can provide support to these projects, potentially strengthening the much needed political and financial support.

1.2 Traditional focus of evidence: HIV prevention for PWID

Globally, most harm reduction interventions are funded under the umbrella of HIV-prevention, focussing on interventions such as needle exchange, HIV-testing and -treatment. This primarily targets PWID, unfortunately leaving out those who smoke, snort or swallow their substances. Researchers have traditionally filled the documenting gap left by service providers, but here too most research funding goes to HIV (and to a lesser extent HCV/HBV) prevention among PWID.

The service users are usually injection opioid users. And harm reduction thus becomes associated with heroin use. Even in countries where harm reduction for heroin users is integrated into the public health care system, solid harm reduction policies for new groups of PWUD (often using stimulants) are scarce.

Fortunately, recent years have shown a slow increase in projects offered and the body of literature analysing harm reduction strategies for non-injection and for stimulants. It is due to this increasing volume of work that a systematic literature review of harm reduction for stimulant use is of great value.

1.3 Objectives of this study

This study builds and collects existing evidence on harm reduction interventions for non-injection stimulant users. Considering social, cultural, political, legislative and religious differences, it seems unlikely that one single intervention will address the many issues experienced by people who use stimulant drugs across the world. Hence, this study looks at specific drugs, routes of administration, groups of users, types of interventions and contextual variations.

The present study:
· Provides a global literature review of harm reduction activities for PWUS;
· Documents, describes and analyses seven examples of good practices of harm reduction for PWUS in different world regions;
· Contributes to guidance in supporting harm reduction for PWUS;
· Stimulates a harm reduction narrative that moves beyond HIV and focuses on human rights and quality of life for PWUS.

In chapter 2 we describe our methodology. Chapter 3 gives more information on the context. This includes information on stimulants, risks and harms of stimulant use, and the *risk environment* in which stimulant use takes place. Chapter 3 describes the findings of our literature review, presenting twelve different forms of harm reduction interventions for PWUS. Lastly, in chapter 4, we describe seven of these interventions through in-depth case studies in different world regions.

2 Methodology

This study consists of two parts: a literature review on the evidence of the effectiveness of harm reduction strategies for stimulant drugs, and a presentation of seven good-practice examples of harm reduction programmes for PWUS in different world regions. Realising that global harm reduction interventions are manifold, and that similar programmes are run at different organisations around the world, the seven cases we describe are good examples of how to put solid (stimulant) harm reduction interventions into practice. Our report presents the first ever comprehensive and comparative overview of evidence and practices on harm reduction for people who use stimulants. It combines a thorough literature review on different stimulants and routes of administration with an in-depth description of real-life examples of good harm reduction practices for people who use stimulants across the world.

2.1 Literature review

We reviewed academic literature in the databases of PubMed, SCOPUS, and Scielo. In PubMed and SCOPUS, we accessed a range of indexed articles in English. Through Scielo, we accessed scientific and scholarly literature from Latin American countries, both in Spanish and Portuguese. Besides, we conducted a thorough review of relevant research publications, local, national and international reports, studies and evaluations, publications from international agencies (e.g. Harm Reduction International, EMCDDA, WHO, UNODC, UNAIDS etc.) and other grey literature. These contributed to the study by describing local contexts and innovative approaches, which were not yet addressed in academic studies. Through Google Scholar we retrieved relevant non-indexed material, including both controlled and uncontrolled, and quantitative and qualitative studies. The following main search terms were used: "harm reduction" and "stimulants", "psychostimulants", "crack cocaine"; "cocaine", "Amphetamine Type Stimulants (ATS)", "methamphetamine", "amphetamine(s)", "cathinone(s)", "chemsex", and "female".

Literature was included from the period between 1998 until 2018. This includes both relatively recent studies, while also largely covering the earlier years, with the arrival and spread of crack-cocaine use, and the rise of ATS use worldwide. We found over 1500 publications, which we narrowed down to include only the most relevant in the review. Eligibility criteria included: reporting on the efficacy or outcomes of harm reduction measures to stimulant drugs, systematic reviews or meta-analyses on harm reduction for stimulants, non-systematic reviews if produced by internationally recognised organs in the drug policy field. Exclusion criteria consisted of: focus only on harms but not on harm reduction strategies, focus on abstinence orientated treatment, not directly focusing on harm reduction, and insignificance to the focus of this research.

The selected literature was clustered into 12 types of harm reduction strategies or interventions for which we found evidence of effectiveness in reducing the

harms of stimulant drugs use. These interventions are safer smoking kits, prevention of sexual risks, female focused interventions, drug consumption rooms, self-regulation strategies, housing first, substitution, outreach and peer-based interventions, drop-in centres, drug checking, online interventions, and therapeutic interventions. The evidence found for these interventions is described in chapter four.

2.2 Seven good practice cases

The selection of good practice cases was guided both by the literature review and by initial consultations with various partners. The literature guided the type of interventions to focus on, and in some cases, the region or country where the intervention was best developed and/or documented. The initial consultation with our network of organisations involved in harm reduction, allowed us to engage with relevant projects, regardless of their appearance in the literature. This proved very valuable, since, very often, innovative actions have not (yet) featured in publications. In total, we contacted more than 50 different projects in around 30 countries, using a snowball method departing from the team's network.

Criteria to select the seven cases were: available evidence on effectiveness, sustainability and/or cost-effectiveness of the project (preferably by previous studies and evaluations or, otherwise, by positive evaluation of local/regional networks of harm reduction and PWUD); projects' potential for replicability; willingness to cooperate in the study; and being recognised as a good practice among harm reduction professionals and PWUD in its region. Cases meeting these criteria were then selected to achieve a diverse representation of: types of harm reduction interventions, types of stimulants (e.g. amphetamines, methamphetamine, freebase cocaine, and new psychoactive substances), rituals of use (user context), key-populations, gender aspects, types of drug policy in place, and geographical regions (ensuring roughly equal representation between the Global North and Global South).

Our final selection of cases includes: housing first for people using freebase cocaine in Brazil, contemplation groups for people using methamphetamine in South Africa, drug consumption rooms for people using freebase cocaine in the Netherlands, out-

reach work for people using methamphetamine in Indonesia, drop-in centres for people using cocaine base paste in Uruguay, distribution of safer smoking kits for people using methamphetamine and/or freebase cocaine in Canada and an online intervention for people using stimulants while practicing chemsex in Spain.

Similar methods and instruments were applied to all cases to ensure that the results were comparable and reliable. For all seven cases, the research team analysed the programme's local documents and studies of effectiveness, carried out a structured questionnaire collecting the programme's data, and interviewed in-depth at least 8 service providers and 2 service users. In five out of the seven cases, in-depth interviews were done *in situ*, along with a more in-depth field incursion. For these cases, additional data was collected through observations and focus group discussions (FGD) with PWUS. Observations included the local context, service providers' activities, the relationship between service users and service providers, as well as any programme specifics considered relevant by PWUS. The FGDs consisted of around 10 PWUS and allowed us to get more in-depth information on service users' perspectives. The five field incursions happened in Brazil, South Africa, the Netherlands, Indonesia, and Uruguay. In the remaining two cases – in Canada and in Spain – research was carried out remotely. Interviews were done over Skype and telephone, and additional data collection was done by e-mail, no field observations or FDGs were carried out. This method was primarily selected due to the time constraints of this study. We ensured that the two remote cases met the following criteria: sufficient reliable data available through peer-reviewed studies and/or international reports, strong local experts, good internet connection for Skype interviews, and availability of the team and service users to be interviewed remotely.

To ensure comparability and reliability, a well-structured and defined set of instruments was applied to all seven cases. The instruments for this study consisted of: structured online questionnaire, semi-structured interviews with professionals, guidelines for FGDs, guidelines for observations, and screening questions for programmes. To comply with Ethical issues and Data Protection Guidelines, all programmes signed a consent form allowing the

disclosure of its shared data, to ensure a transparent and comprehensive description of the local best practice. Moreover, all respondents – including the participants in the FGDs – signed a consent form assuring their anonymity and had the right to withdraw from the study at any moment. Each respondent was given a code and organisations were only mentioned upon explicit consent. All (anonymised) data was stored at a secured and backed-up server, only accessible by the research team. Pictures in the report were screened to assure anonymity of all participants.

2.2.1 Meaningful involvement

There is growing recognition of the need for more meaningful involvement of community members, in public health programming. For example, the importance of human rights and community empowerment has been identified as a key enabler in the HIV response (UNDP and UNAIDS 2012), and the new normative guidance to implement comprehensive HIV and HCV programmes with people who inject drugs (UNODC et al. 2017a). Peer-led PWUD advocacy groups such as the International Network of People Who Use Drugs (INPUD) have been calling for more meaningful involvement of PWUD through the promotion of the practice 'Nothing About Us, Without Us' (Jürgens et al. 2008).

Especially for services that need to consider *new* user groups such as people who smoke crack cocaine or methamphetamine, it is of the utmost importance to include beneficiaries in a meaningful way. A key element in determining the effectiveness of the interventions studied for this research is, therefore, the experience of the population in question. Since community members themselves are experts in the harms that they experience, it is imperative to work with the community to not only effectuate change but also capture factors in the socio-cultural environment that have been instrumental in reducing substance use-related risks within a context. The perspectives and motivations of PWUS are critical in understanding the factors enabling or hindering harm reduction interventions. Hence this study included – as much as possible – the perspective of PWUS, for instance through interviews and FGDs.

3 Context

Stimulant drugs, also called psychostimulants or more colloquially *uppers*, are psychoactive substances that stimulate the brain and central nervous system. The most common effects of stimulants include increased alertness, elevated mood, promote wakefulness, increased speech and motor activity and decrease fatigue and appetite. They increase blood pressure, heart rate and other metabolic functions (Pinkham and Stone 2015). Stimulants can induce feelings of energy, focus, confidence, alertness, well-being, talkativeness and increased sex drive, but can also produce nervousness and anxiety (Grund et al. 2010).

Globally, the two most popular stimulants are the legal drugs caffeine and nicotine. These, however, will not be addressed in this report, which focuses mainly on problematic use of illicit stimulant drugs, namely: amphetamine type stimulants (ATS), cocaine, and cathinones. Traditional use of plant-based (mild) stimulants such as khat, ephedra, kratom and coca leaf are excluded from this report, as there is no (reliable) data available on the role these substances play in problematic drug use globally. Although MDMA is a substituted amphetamine and it does have stimulant properties, its effects are more properly classified as an *entactogen*. In addition, since MDMA use is less associated with marginalised populations, the report does not focus explicitly on MDMA. Finally, synthetic prescription stimulants such as methylphenidate (e.g. *Ritalin, Concerta*) and dexamphetamine (e.g. *Adderall, Dexedrine*) or wakefulness-promoting agent modafinil (*Provigil*) are also not discussed in this report.

Besides licit and illicit substances, another distinction can be made between traditional and novel illicit drugs (best known as new psychoactive substances, or NPS). In 2017, 36% of all NPS on the global market were stimulants (UNODC 2018a). Traditional illicit stimulants include amphetamine and methamphetamine as well as cocaine hydrochloride and freebase cocaine. The stimulant NPS discussed in this report are (substituted) cathinones, since this is the most common stimulant NPS and problematic use of synthetic cathinones has increased globally.

The following chapters will discuss the three main categories of illicit stimulants: ATS, cocaine and cathinones. In general, we use *cocaine* when referring to the substance in either salt or free-base form. For the sake of readability, and acknowledging the different terminologies used across the world, as well as opinions on the use of certain terms used, we do frequently use *crack* or *crack cocaine* to refer to smokable, free-base cocaine throughout the report. Likewise, we use *amphetamine-type substances* or *ATS* to refer to any amphetamine-like substance, and frequently use the shorter *meth* instead of the more correct *methamphetamine*.

3.1 Amphetamine Type Stimulants

ATS are a group of chemically and structurally related synthetic drugs that are powerful central nervous system stimulants. They increase activity of the dopamine and noradrenaline neurotransmitter systems and raise levels of dopamine and

norepinephrine in the brain. Amphetamines belong to the phenethylamine family, which includes stimulants, entactogens and hallucinogens, but are also their own structural class. Aside from its illicit use, amphetamines may be prescribed for a variety of conditions, such as attention deficit hyperactivity disorder (ADHD) and narcolepsy (Pinkham and Stone 2015).

The nomenclature of many stimulants, particularly of ATS, can be confusing and is frequently used inconsistently, both in academic literature as well as in layman's language. For this report, when referring to amphetamines or ATS, we typically refer to amphetamine, dextroamphetamine and analogues and substitutes whose primary effect is that of a psychostimulant. This excludes MDMA, MDA and similar *entactogen* compounds, but includes methamphetamine and analogues. Street names for these substances are also used inconsistently and vary immensely between regions and user groups. In this report, whenever a locally relevant street name is mentioned it will be explained in context.

Amphetamines are available in a variety of forms, such as white or off-white powder, in pill form, as an oily substance, and in crystalline form. Each form is associated with a different route of administration. The free-base form is most commonly smoked, chased (smoked from foil) or vaporised. Pills are usually taken orally, while powder and crystals can be snorted and injected. However, there is no direct association between form and mode of administration, and these may differ between use groups, individuals, location, and change over time.

Globally, ATS are the second most commonly used drugs, with cannabis ranking first. It is estimated that around 34.2 million people have used an amphetamine-type substance in the past year, ranging between 13 million and 58 million, and its use seems to be on the increase (UNODC 2018b). IDPC (2016) reports that civil society organisations, academics, NGOs and international agencies all report increasing ATS use in every region of the world. The highest prevalence of ATS use is in North America and Oceania. Although no reliable data are available, many countries in Asia report increases in methamphetamine use (UNODC 2018b; EMCDDA 2018b).

Despite the acceptance of harm reduction as a legitimate approach in several Asian countries, the region's leading treatment for ATS users is still compulsory residential centres focused on achieving abstinence. Human rights abuses have been reported in many of those centres, and the compulsory in-patient strategy lacks proof of effectiveness (WHO 2011). Most harm reduction services available in the region focus on people who inject opioids. People who use ATS rarely use harm reduction services, largely because they do not identify themselves with (problematic) opioid use, often belong to different networks of users, and thus do not perceive harm reduction services as relevant to them (WHO 2011) they require information and counselling to enable them to appreciate the potential risks from ATS use and take measures to mitigate these harms.

In most other regions too, there are relatively few harm reduction programmes specifically for people who use ATS. Moreover, although ATS use has been rising over the globe, ATS-specific interventions and evidence supporting them remains underdeveloped (Pinkham and Stone 2015). In light of this, Harm Reduction International produced a global review addressing the ways in which harm reduction programmes can respond effectively to reduce the harms associated with ATS use and offering future recommendations (Pinkham and Stone 2015).

3.1.1 Methamphetamine
Methamphetamine is structurally very similar to amphetamine but is more potent and its effects usually last longer. Methamphetamine can come in two physical forms, base and salt. The pure base is a clear, colourless volatile oil, insoluble in water, which can be easily heated and inhaled. The most common salt-form is methamphetamine hydrochloride. On the illegal market, it is frequently sold in pill, powder or crystalline forms. The crystalline solid is often called *shabu* in South East Asia but is also frequently named *ice* or *crystal meth* due to its appearance. In East and South-East Asia, methamphetamine in tablet form is common. These pills, generally called *yaba*, are typically of low purity, and may contain several other (psychoactive) substances in addition to methamphetamine. While pills can be taken orally, or sometimes crushed and smoked, the crystals can be crushed, dissolved and injected, but can also be smoked without being destroyed by the heat.

Powdered methamphetamine is usually adulterated with an additional substance such as caffeine, dextrose or lactose, and can be taken orally, intranasally (snorted) or dissolved and injected.

According to the World Drug Report 2017, East and South-East Asia and Oceania have been the main recipients of internationally trafficked methamphetamines over the past years. Moreover, a lot of intraregional trafficking happens in North-America, Europe as well as East and South-East Asia. The high prevalence of methamphetamine use is not only apparent through trafficking surges, but also through limited information on people in drug treatment. For instance, in 2014 Indonesia experienced a huge upsurge of people in treatment for methamphetamines. In 2015 experts claimed methamphetamine to be the most used drug in China, Japan, Macao, the Philippines and Singapore (UNODC 2017).

In Europe, only in the Czech Republic is meth (known locally as *Pervitin)* traditionally the number one problem drug. Although cannabis is the most commonly used drug, followed by MDMA, *Pervitin* is most linked to high-risk and problem drug use; This has been the case for over four decades (EMCDDA 2017a; Pates and Riley 2010). In serval other European countries an increase of methamphetamine use has been witnessed among MSM who use it in a sexual context (chemsex), in recent years.

3.2 Cocaine
Cocaine is extracted from the leaves of Erythroxylum coca species. This plant is endogenous to the Andes and adjacent regions in South America. The stimulant has a short half-life, increasing levels of dopamine, serotonin and norepinephrine in the brain. Cocaine comes in many forms, such as hydrochloride salt (*coke*), freebase (*crack*), or crude extracts called coca paste (*paco, basuco, pasta base, PBC*). Cocaine HCl and freebase cocaine are the most commonly used forms in the west (Degenhardt et al. 2014) a Bayesian meta-regression tool, using epidemiological data (prevalence, incidence, remission and mortality. Cocaine paste is mostly used in Latin America. Cocaine can be used in various ways, it can be snorted, injected, smoked or taken orally. Typically, cocaine HCl is snorted, while freebase cocaine and coca paste are smoked.

Cocaine paste is a crude intermediary product in the extraction of cocaine hydrochloride. Coca leaves are typically mixed with chemicals such as methanol, sulphuric acid and kerosene. The paste is a crude extract that can be further processed to yield cocaine hydrochloride. Compared to freebase cocaine and cocaine salt, coca paste is relatively inexpensive and mostly used in Latin American countries.

Freebase cocaine is made suitable for smoking, typically by processing cocaine HCl with either ammonia or baking soda (sodium bicarbonate). This form of freebase cocaine attained its popular street name *crack* due to the sound it makes as it's smoked. Although there are no precise estimates of its prevalence, it is safe to say that freebase is widely available in the Americas and increasingly in Europe. Predominantly used by marginalised groups and among street-based populations, numerous European, and North-, Central- and South-American countries have reported crack use problems (Fischer, Blanken, et al. 2015). Comprehensive reviews on the global state of interventions for freebase cocaine use are lacking (Fischer, Blanken, et al. 2015).

According to the World Drug Report 2018, based on data from 2016, estimates are that 18.2 million people used cocaine in the past year. This represents 0.4% of the world population between 15 and 64 years of age (UNODC 2018b). These numbers correspond with earlier studies (2012 and 2014) that estimate the global number of cocaine users between 14 and 21 million, accounting for somewhere around 0.3 – 0.5% of the world population (Fischer, Blanken, et al. 2015). In the North- Central- and South America the prevalence of cocaine use is estimated to be even higher, with studies indicating a prevalence rate of 1.4% or higher. In the Americas, cocaine is the second most commonly used illicit drug following cannabis. More than half of all people who use cocaine are in the American continent, with 34% of the global total number of people using cocaine North America. This is followed by 20% in Western and Central Europe, and 17% in South and Central America, including the Caribbean. The remainder 30% have not been specified in the report (UNODC 2018b).

3.3 NPS and Cathinones

New psychoactive substances (NPS) are often classed together as if they were a homogenous group of substances. However, NPS include substances as diverse as synthetic cathinones, novel psychedelic drugs, synthetic cannabinoids, synthetic opioids and others. Stimulants (36%) make up the biggest group of all novel substances, followed by cannabinoids (32%) and psychedelics (16%) (UNODC 2018a).

Many stimulant NPS belong to the cathinone group. Again, when looking at the European market, synthetic cathinones are the second largest group of monitored NPS (after synthetic cannabinoids) with 130 different synthetic cathinones registered (EMCDDA 2018b). The most well known in this class is mephedrone, also known as 4-methyl methcathinone (4-MMC). Mephedrone was first synthesised in 1929, but only became widely available in 2007. Since then it has been rescheduled as an illegal drug in at least 31 countries (Harm Reduction International 2016).

Cathinone is the active substance in fresh khat, a North African shrub whose leaves have a mild stimulant effect when chewed. Methcathinone is stronger than cathinone, having similar but more intense effects. Other novel cathinones include 3-MMC, 4-MEC and flephedrone, among many others.

The NPS environment is a continuously changing landscape, with new substances appearing on the market with great frequency. This makes it difficult and often impossible to adequately, and in a timely fashion, inform users about the effects and risks of particular substances. This also applies to stimulant NPS. For instance, in Europe, by the end of 2017 the EMCDDA was monitoring more than 670 NPS. Almost 70% of these substances were detected in the last 5 years, with 51 new substances in 2017 alone (EMCDDA 2018b).

3.4 Potential risks and harms

As is arguably the case for all harms related to (illicit) substance use, many adverse health and social consequences are mediated by the risk environment in which they are used. Structural aspects of the risk environment such as unemployment, poverty, homelessness, unstable housing, and incarceration, as well as adulterants, (lack of) availability of harm reduction services, drug legislation and public policies can all have a negative impact on the lives of PWUD (EMCDDA, 2017). This is no different for people who use stimulant drugs. There is a considerable amount of scientific literature on harm related to the use of stimulants and it is beyond the scope of this report to reiterate or recap those findings. In this chapter, we will summarise the most important findings on those categories of harm that are more strongly linked to non-injection use of stimulants. To keep it concise, we have chosen not to differentiate between specific substances, but rather focus on those harms that apply to the stimulants discussed in this report.

3.4.1 Physical harm
Routes of administration
The potential negative health consequences associated with the use of stimulant drugs is partly substance-dependent and partly related to specific routes of administration. Problematic consumption patterns and dependence, for example, happen more commonly among people who inject or smoke stimulants – regardless of the substance they use (EMCDDA 2018a). Harms become more likely after intensive, high-dose or long-term stimulant use (Grund et al. 2010). However, acute problems can also occur after occasional and/or low-dose stimulant use (EMCDDA 2017b).

As with opioids, the transmission of infectious diseases (e.g. blood-borne viruses such as HCV and HIV) is strongly linked to injection. An additional risk for people who inject stimulants is that they often inject more frequently, are more likely to share needles and syringes, often have more chaotic injecting practices and also engage more frequently in risky sexual activities compared to people who inject heroin (Grund et al. 2010; Folch et al. 2009). Grund et al. (2010) have created an overview of the relation between (injection) stimulant use and HIV and HCV (Grund et al. 2010, 194–95). More recently, the UNODC (2017) also published a systematic literature review on the relation between stimulant use and HIV.

Damage to the lungs is strongly linked to smoking stimulants, most notably smoked cocaine (Jean-Paul Grund et al. 2010). People who smoke stimulants can also transmit diseases by sharing pipes and other materials. For instance, metal and glass pipes

can burn one's mouth, and – especially street-made – paraphernalia can have sharp edges resulting in small wounds (Strathdee and Navarro 2010; Hunter et al. 2012) a finding that supports program cost-effectiveness. While SIFs remain controversial, there are at least 90 SIFs in 40 cities globally. To this end, SIFs are becoming increasingly viewed as a necessary component of a comprehensive strategy to reduce drug-related harms and facilitate uptake of medical care and drug treatment among street based drug users. The rationale for SIRs may be less obvious than that for SIFs, but is no less important. The observations were unfortunately not accompanied by systematic data collection, although transitions from injection to non-injection drug use in Spain have been documented concomitant with a comprehensive harm reduction approach. It therefore seems reasonable to hypothesize that co-existence of SIFs and SIRs could promote transitions from injection to non-injection, thereby reducing the risk of blood-borne infections in the community. In our view, it is high time to consider the potential role of SIRs in reducing drug-related harm, and to facilitate rigorous evaluations so that drug smokers are not left peering through the two-way mirrors, waiting to inhale. (PsycINFO Database Record (c. Oral sores and cracked lips make people vulnerable to infectious diseases. HCV present in saliva or nasal fluid can be transmitted by sharing pipes (Grund et al. 2010). Studies have also demonstrated that smoking methamphetamine is associated with the transmission of HCV and HIV infections among female sex workers (Strathdee and Navarro 2010; Ontario Needle Exchange Network 2007).

Snorting cocaine and methamphetamine can lead to the narrowing of nasal blood vessels, resulting in damaged or dying cartilage. This may lead to a hole in the septum and/or *collapsed* noses (Grund et al. 2010).

Physical risks
All stimulants significantly increase blood pressure and heart rate. It is a well-established fact that cocaine is cardiotoxic (Phillips et al. 2009). Cocaine can cause irreversible structural damage to the heart, exacerbate existing cardiovascular diseases, and even cause sudden cardiac death. Cocaine use is linked to heart attacks, irregular heartbeats, heart failure and other cardiovascular problems (Phillips et al. 2009). Combined use of cocaine and alcohol leads to production of coca-ethylene in the human body. This novel metabolite further increases cardiotoxicity (Herbst et al. 2011). ATS use has been associated with dental decay and dental diseases, although it is unclear how much of this is a direct result of (meth)amphetamine use or related to poor diet and personal oral and dental hygiene (Grund et al. 2010).

Another risk is caused by improper synthetisation of stimulants – for instance when they are home produced. Stimulants may contain toxic chemical residues or other impurities. Some of these impurities are associated with high levels of morbidity and many complex health issues such as the spread of blood borne viruses, gangrene, and internal organ damage, as well as with cognitive defects, dementia-like memory issues, gangrene haemorrhage and parkinsonism (Grund et al. 2010; Hearne et al. 2016).

Overdose
While fatal overdoses on stimulants do occur, these are seldom seen among PWUS who frequently use high doses. This is most likely because of the development of tolerance. Heart attacks, arrhythmia and strokes are the most frequent cause of overdose for people who use cocaine (Jean-Paul Grund et al. 2010). Overdoses of methamphetamine can lead to seizures, heart attacks, stroke, kidney failure and potentially fatal elevated body temperatures (Matsumoto et al., 2014). Combined use of cocaine with opioids, alcohol and other depressants is closely linked to cocaine overdoses, just as the use of cocaine is associated with increased chances of opioid overdoses (Jean-Paul Grund et al. 2010).

Risky behaviour
Numerous studies have identified both direct (substance use) as well as indirect (e.g. sexual) risk behaviours related to the use of stimulants. The indirect risks affect – for instance – rates of infectious diseases such as HIV, HBV, HCV and TB. Reportedly, the prevalence of infectious diseases is even higher among people who use crack cocaine in comparison with other illicit substances (Fischer, Blanken, et al. 2015). The use of methamphetamine in particular has been associated with increased risky sexual behaviours, in part by increasing sex drive and enable longer sexual episodes (Hunter et al. 2012).

We discuss these risks, and ways of managing them, in more detail in chapter 4.2.

Dependence

Whereas the vast majority of PWUS does so occasionally and without much risk, a minority develops a pattern of heavy and frequent use that produces dependence. Although physical dependence of stimulant drugs is not comparable to that of depressants such as heroin, GHB or alcohol, PWUS can and do experience withdrawal symptoms. These include agitation, fatigue, increased appetite, unpleasant or intense dreams, sleep disturbances, cognitive impairment, (temporary) psychotic-like symptoms, and psychological distress. Typically, these start within a few hours after last use and may last up to several days (Degenhardt et al. 2014; Fischer, Blanken, et al. 2015). According to the World Health Organization, withdrawal from stimulant drugs is not medically dangerous (WHO 2011). Nevertheless, over the years, researchers and PWUS alike, have looked for substances that can support maintenance therapy, reduce stimulant use or reduce the adverse effects associated with its use, similar to the role of methadone and buprenorphine for people who use heroin. This is elaborated on in chapter 4.7.

3.4.2 Mental health harms

Studies have shown high levels of psychiatric comorbidity (e.g. suicidality, depression, PTSD, AD(H)D, personality disorders) among chronic stimulant users (Grund et al. 2010; Fischer, Kuganesan, et al. 2015). Problematic use of cocaine HCl and crack, for instance, has been associated with anxiety, depression, paranoid thoughts, and increased aggressiveness (Haasen et al. 2005). Methamphetamine use has been associated with negative thoughts about oneself, symptoms of depression, psychotic symptoms (such as hallucinations), increased aggressiveness and paranoid thoughts (Zweben et al. 2004; McKetin et al. 2006). Chronic amphetamine and cocaine use are also associated with psychosis, although this is mostly transient and typically takes place after periods of extended use or during withdrawal (Grund et al. 2010; Morton 1999). Pre-existing psychotic-like symptoms can worsen after stimulant use. After excessive use of stimulants and combined with the resulting sleep deprivation, some PWUS can develop a condition known as *delusional parasitosis*. One of its symptoms, known as *formication,* is the sensation that insects (sometimes called *coke bugs*, *amphetamites* or *meth mites*) are crawling on or under one's skin. Scratching, picking or cutting the skin can result in skin lesions, which in turn can get infected (Grund et al. 2010).

3.4.3 Social Harms

Problematic stimulant use is associated with a host of social problems and people in more vulnerable socio-economic conditions may be more likely to have problems related to their substance use. Both the use of stimulants and the association with illegal stimulant markets are linked with social and economic marginalisation, and increased crime rates such as property crimes and violence (Fischer, Blanken, et al. 2015). As with other illicit substances, the criminalisation of stimulants creates its own dynamic, resulting in social and economic marginalisation, in turn leading to poorer access to and lower uptake of social, health and treatment services (Strathdee and Navarro 2010). While we must exercise caution in suggesting causal links, people with problematic stimulant use are more likely to be unemployed, have limited social support and a chaotic lifestyle (Jean-Paul Grund et al. 2010). Problematic stimulant use is also linked to 'social and family problems, including poor interpersonal relationships, child abuse or neglect, job loss, motor vehicle accidents, trading sex for money or drugs, criminal or violent behaviour and homicide' (Grund et al. 2010, 202).

3.4.4 Risk Environment

Building on Norman Zinberg's influential 'Drug, Set and Setting' (1984), which suggested that environmental factors played an important role in people's ability to maintain control over their drug use, Tim Rhodes introduced the concept *risk environment* to explain the relation between drug use, and drug-related harms and social context (Rhodes 2002, 2009). Both Zinberg's *setting* and Rhodes' *risk environment* are not static, but a complex interplay between individual users and social, cultural, economic, legal and other variables that therefore frequently changes. Drug use, associated harms, and harm reduction interventions are all environmentally situated, and contingent upon the social context, or risk environment. Rhodes distinguishes two levels of risk environment: micro and macro. The micro risk environment considers personal decisions as well as the influence of community level norms and practices (Rhodes and Simic 2005). The

macro-environment looks more at structural factors, such as laws, military actions, economic conditions, and wider cultural beliefs (Rhodes and Simic 2005). Traditionally, most public health interventions have focused on changing individual risk behaviours. However, Rhodes' model shows that using substances does not take place in a vacuum, but rather in a specific social, cultural, economic, legal, policy, and political environment. Maintaining control over one's use, and thus managing both individual and social harms, depends to a great deal on external social mechanisms, including rituals, social controls and other rules (Zinberg, 1984; Grund, 1993). It is not a characteristic of a specific type of user, but rather a dynamic process that depends on a variety of factors and environments (Forum Droghe and Transnational Institute 2014). Applying the same model to interventions shifts the emphasis from individual PWUS to the social context in which people take drugs (Grund, 2017; Rhodes, 2009). This implies that harm reduction interventions for PWUS always need to take into account the risk environments of beneficiaries (Grund et al., 2010; Rhodes, 2002).

Literature review

4 Literature review

In the last decades, an increasing body of literature has been produced around harm reduction strategies for stimulant and non-injection drugs use. Most of the studies are local, focusing on a specific programme or strategy. Others focus on specific regions or cover broader regions but focus on specific stimulants. Besides these, few but valuable reviews of harm reduction strategies for stimulant drugs are already available.

Grund et al. (2010), for instance, reviewed 91 academic studies about ATS and cocaine between 1990 and 2018. These were mostly published in English but the authors also included a few German and French studies. The authors found that most of the available literature around stimulant use still focuses on the harms of stimulants, rather than on strategies that are aimed at reducing the harms or risks of using stimulants. From the literature focusing on harms, most articles focus primarily on medical health consequences (blood-borne viruses and other infection complications, neurologic problems, heart and lung complications, overdose, and pregnancy). Mental health and other problems associated with stimulant use are addressed only very briefly. Some strategies recommended by the authors to reduce harms of stimulants use include: 'crack kits' (safer smoking kits for crack cocaine), supervised consumption facilities, limiting mixture of substances, providing brief interventions, and sexual protection supplies (Grund et al. 2010).

Fischer et al. (2015) focused on crack cocaine use and dependence. They carried out a systematic review of academic studies on the efficacy of secondary prevention and treatment interventions for crack cocaine. The authors considered studies between 1990 and 2014, English-language only. They note that a comprehensive reviews on the state of interventions for crack use are lacking, and that targeted prevention and treatment measures specifically aimed at crack cocaine use have, still, limited availability (Fischer, Blanken, et al. 2015).

International and regional agencies have also produced valuable reviews on interventions targeting stimulant use. The World Health Organization (WHO 2011) provides an overview of interventions related to ATS, focusing on non-problematic users. The review states that the majority of people who use ATS (around 90%) do not require intensive treatment interventions, as their use is casual or experimental. In this context, information and counselling are the best measures to help people appreciate the potential risks from ATS use and create their own strategies to reduce harms. Crisis interventions strategies are useful tools for dealing with critical moments of paranoia or withdrawal symptoms (WHO 2011).

Harm Reduction International (Pinkham and Stone 2015) offers a good overview of harms related to the use of amphetamines, along with a description of concrete harm reduction responses. The authors say that harm reduction for amphetamines follows

the same fundamental principles as harm reduction for people who use opioids: we should meet people where they are, provide information and activities based on people's needs, provide outreach and mobile services for those unwilling to visit a harm reduction site, engage peers as staff members, volunteers or advisors, and refer people to other relevant services. Regarding harm reduction for people who use stimulants, the report stresses the importance of hydration and dental hygiene, developing controlled patterns of use, making use of safer smoking kits, developing strategies to deal with paranoia, delusions and anxiety, and making conscious and informed decisions on the functional use of stimulants for work or sexual purposes (Pinkham and Stone 2015). For people who use methamphetamine, the following suggestions are added: eating a balanced diet, getting enough rest and not going more than two nights without sleep, and getting into a regular pattern of eating, drinking and sleeping. It is also thought helpful to make PWUS aware of impending signs of psychotic-type symptoms, urging them to call on friends or family in case of anxiety, paranoia or panic to help calm one down, and finally, to help PWUS attend to substance-use related lifestyle issues such as oral and dental hygiene (Department of Medical Services 2017; The Australian Drug Foundation 2016). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) offers a review on the use of psychosocial interventions for drug treatment in general, which includes treatment for stimulants (EMCDDA 2016). The EMCDDA also provides a best practice portal for treatment of problematic use. The portal features interventions that were evaluated positively in systematic reviews or guidelines with specific methods for assessing evidence. Best practices, in this context, are those for which 'precise measures of the effects in favour of the intervention were found' (EMCDDA 2018a). According this criterion, best practices for treatment of stimulants found by EMCDDA focus on psychosocial or behavioural interventions, and, to a lesser extent, pharmacological interventions including substitution therapy. Psychosocial interventions, for instance, can help people reduce their cocaine use by influencing mental processes and addiction behaviours. Medications (such as disulfiram and antiparkinsonians) may also help reduce cocaine use, while some drugs to treat depression (like fluoxetine and imipramine) can improve the adherence to

treatment for people who use methamphetamines (EMCDDA 2018a).

Other reviews are more specific, focusing for instance on pharmaceutical substitution strategies for amphetamines (Pérez-Mañá et al. 2013; Shearer and Gowing 2004). The UNODC (2017) recently published a five-part literature review on the links between stimulant use (ATS, cocaine, and NPS) and HIV transmission risks, as well as on treatment and prevention of HIV, HBV and HCV. This review describes several harm reduction interventions that have proven effective in preventing HIV transmission. These include providing condoms and lubricant, safe injection and safe smoking equipment, information, counselling, testing for communicable diseases, and treatment such as pre- and post-exposure prophylaxis (PrEP and PEP), among others.

There is an increasing amount academic and non-academic evidence on what is effective to reduce the harms of stimulant drugs use is increasing. It is due to the increasing volume of work, and the increasing practical need, that a systematic literature review of harm reduction strategies for stimulant drugs' use is of great value. Our review includes interventions for various types of stimulants, diverse routes of administration, and in different regions of the world. We have clustered the studies into 12 harm reduction strategies: safer smoking kits, prevention of sexual risks, female focused interventions, drug consumption rooms, self-regulation strategies, housing first, substitution, outreach and peer-based interventions, drop-in centres, drug checking, online interventions, and therapeutic interventions. These are described in the following chapters.

4.1 Safer smoking kits

Safer smoking kits can be used as a harm reduction strategy for both crack cocaine and methamphetamine. To date, however, studies on safer smoking kits still heavily concentrate on crack use only. The content of safer smoking kits for crack varies in the different countries where it is distributed, but a complete kit typically contains: a pipe (usually a heat-resistant glass stem or, alternatively, a wooden pipe); a rubber or silicone mouthpiece; screens (made of steel or brass); substances used to protect the lips (lip balm

or petroleum jelly); information about safer drug use (including prevention of sharing equipment and safe disposal); and safer sex information and materials (condoms and lubricant). Sometimes kits may also include items, such as ascorbic acid, to prepare crack for injecting or items to prevent infections or the spread of blood-borne viruses (alcohol swabs, hand wipes).

A number of studies found that the distribution of safer smoking kits increases safer smoking techniques and practices, and significantly decreases injection practices (Jozaghi, Lampkin, and Andresen 2016; Leonard et al. 2008; Ti et al. 2012). This is likely because sharing equipment becomes more likely for people who have difficulty accessing (low cost) crack pipes, particularly street-based young PWUS (Cheng et al. 2015). Availability of high-quality smoking equipment decreases PWUS' reliance on unsafe equipment, reducing negative consequences such as exploding pipes or inhaling metallic particles (Prangnell et al. 2017). The distribution of crack pipes through health service points increases the uptake of these kits, while decreasing health problems related to crack smoking.

Safer crack smoking kits have been found to help prevent injuries to the mouth and lungs (Malchy, Bungay, and Johnson 2008; Collins, Kerr, Tyndall, et al. 2005; Porter and Bonilla 1993). Filters will reduce exposure to hot residues, helping to reduce burns to the mouth and throat (Jean-Paul Grund et al. 2010). Pipes and (rubber) mouthpieces may reduce cuts and burns to the lips, as well as reduce damage to the lungs and toxicity (Pinkham and Stone 2015; Jean-Paul Grund et al. 2010; Leonard et al. 2008). There is no definitive evidence of the effectiveness of distributing crack kits on disease transmission per se (Hunter et al., 2012; Malchy, Bungay, Johnson, & Buxton, 2011).

One important factor to assure the effectiveness of the intervention is to adapt the kits to users' preferences and needs. This increases the acceptance of safer smoking equipment and prevents PWUS from continuing to use self-made pipes (Poliquin et al. 2017). For instance, glass pipes have an advantage over other pipes as the glass does not disperse aluminum, copper, wood, plastic or any substances that could cause further harm. However, they may not be dsitributed everywhere. For some

programmes, glass pipes might be too expensive. Besides, the design of the stem used in crack kits is not ideal for smoking crystal methamphetamin.Meth liquefies when heated, which and may be inhaled if smoked with a glass stem (Hunter et al. 2012) Even if alternative pipes designs are required, the rationale of the intervention does apply to smoked methamphetamine smoking as well, since many of the risks associated with smoking crack cocaine are shared. It is also important to care for needs which are part of a macro-risk environment. In some countries, for instance, PWUS may avoid carrying pipes for fear of police intervention. Mouthpieces alone, in these cases, can be a good harm reduction possibility. Another alternative may be personal vaporisers, similar to E-cigarettes for tobacco smokers, and other means to filter out talc and other particles. These may further reduce body and lung harms, as vaporization and filtering could reduce the amount of combustion products inhaled (Jean-Paul Grund et al. 2010). At the same time, some PWUD communities may be so used to their own kind of pipes that it can be very complicated to achieve a switch to more sterile instruments delivered by a harm reduction programme. A good harm reduction alternative in these cases is teaching PWUS harm reduction methods that can be used with their more harmful pipes.

One challenge to be addressed when using safer smoking kits as a harm reduction strategy relates to sharing instruments. Even when using the kits, users may continue to share pipes for a number of individual and social reasons (Poliquin et al. 2017; Malchy et al. 2011). These reasons include unfamiliarity with services; experiencing craving and feeling the compulsion to use immediately; being gifted drugs or pipes; or occasional smokers who do not carry the right equipment (McNeil et al. 2015; Ti et al. 2012; Cheng et al. 2015; Roy et al. 2017; Voon et al. 2016). Besides, not all users recognise the risks of sharing equipment and may consider other risks, such as overdosing, to be more important. The context of use also impacts sharing practices to a large degree. Methamphetamine use, for instance, often takes place in a group setting where sharing is common, part of the culture, and not the result of an inability to buy or access new and clean supplies (Hunter et al. 2012). Especially for female users, the sharing of pipes is also frequently the result of power relations, which renders them vulnerable (Bungay et al. 2010a;

McNeil et al. 2015). Addressing these issues requires more than the distribution of safer smoking kits alone.

Prangnell et al. (2017) found, for instance, that a decrease in unsafe equipment use was not found when pipes were obtained from non-health related sources. PWUS who obtained pipes from a health service point reported significantly less health problems related to crack smoking (such as cut fingers, sores or coughing up blood) than the ones using self-made pipes or pipes obtained on the streets. Malchy et al. (2011) suggest that when distribution takes place in the broader context of health services, better results are achieved. Harm reduction messaging should accompany the distribution of kits to decrease the sharing of equipment and unsafe drug use (Malchy et al. 2011). In a broader sense, distribution of safer smoking kits only focuses on the micro risk, and does little to mediate the harms caused by the macro environment (Jean-Paul Grund et al. 2010). Thus, integrated strategies work best: the distribution of safe crack-smoking kits needs to be integrated in broader harm reduction objectives, such as those 'fostering access to health care and psychosocial support, as well as social integration and safety' (Poliquin et al. 2017).

One of the countries where the distribution of safer [crack] smoking kits has been widely implemented and studied is Canada. Canadian best practice guidelines (Strike et al. 2013; Watson et al. 2017) encourage needle and syringe programmes (NSPs) and other harm reduction programmes to distribute safer smoking equipment, educate clients on safer smoking practices, and to provide options for safe disposal of used equipment. Many needle and syringe programmes in Canada also offer safer crack smoking kits and education (Strike and Watson 2017). In chapter 5.4 we describe a Canadian programme working with safer smoking kits.

4.2 Prevention of sexual risks

There is a strong link between stimulant drug use and sexual health risks. They are interrelated in a number of ways:

· Being under the influence of a drug can lead to disinhibition and consequently to unintended sexual activities that may have negative consequences (e.g. mental distress, STDs, pregnancy);
· Engaging in sex work to fund drug use;
· Using substances to enhance sexual performance and pleasure (chemsex);
· Using substances as a coping strategy for dealing with the emotional distress arising from a sexual health problem, such as an HIV diagnosis.

In Europe, treatment services for drug use and sexual health problems are usually separated and rarely co-located, making it harder to address both issues at the same time. Because of the strong interrelation, the EMCDDA (2017) states that integration of services for drug use and sexual health is needed. In any case, expertise should be shared, and services encouraged to work together more closely. Also, a better understanding of risk behaviours and treatment needs is necessary (EMCDDA 2017b).

To a certain extent, prevention of sexual risks is no different for people who use stimulant drugs than for other drug using populations. In any case, sexual health risk prevention should cover: free access to condoms and lubricant, information about STIs and HIV, low-threshold access to HIV and STI testing and treatment, contraception and pregnancy testing and counselling, talking about sexual risk, and developing a plan for self-control over harmful behaviours. Furthermore, addressing sexual and physical violence, transactional and commercial sex, abusive relationships, and other issues related to sexual risk behaviours is also important (Pinkham and Stone 2015).

Some sexual risks, as well as the responding harm reduction and prevention measures, apply more specifically to PWUS. Stimulants tend to dry mucous membranes and decrease sensitivity, increasing the chances of longer and more intense sex. Therefore, PWUS should use plenty of lubricant. This is especially true for PWUS who make use of stimulants to facilitate and improve sexual activity, such as male PWUS in the chemsex scene.

4.2.1 Chemsex

Chemsex is a relatively recent phenomenon that was first documented in the UK, soon followed by other countries in (Western) Europe (Bourne & Weatherburn, 2017), and Asia. The term chemsex is generally used to define the intentional combination

of sex with the use of certain psychoactive drugs, among men who have sex with men (MSM) (Bourne, Reid, Hickson, Torres-Rueda, & Weatherburn, 2015; Giorgetti et al., 2017; McCall, Adams, Mason, & Willis, 2015; Stuart, 2016). Chemsex usually occurs in private settings, such as someone's home, or in chill-outs during multiple-day sex parties (Pakianathan et al. 2016). In the USA and Australia, chemsex is better known as *party and play*.

In these settings, the drugs or *chems* – as they are called in this scene – frequently include the stimulants methamphetamine and mephedrone (4-MMC), as well as GHB/GBL and a variety of other substances. These are often used in combination, to facilitate, enhance and prolong sexual sessions lasting several hours, or sometimes even days, with multiple sexual partners. Some sexual networks also experiment with other substances, including novel stimulants such as the cathinones 4-MEC and 3-MMC, as well as the substituted amphetamine 4-fluor-amphetamine (Knoops et al. 2015a). Most of these stimulants can be injected, or *slammed*, as it's known in the chemsex scene (Pufall et al. 2018; Knoops et al. 2015a). Substances are used to increase euphoria and energy; to stimulate sexual arousal and stamina; to enhance sexual self-confidence, but also to overcome a negative self-image; to facilitate transcending boundaries; to escape worries, feelings of rejection, and concerns about potential STI transmission (Bourne et al., 2015; Bourne & Weatherburn, 2017; Weatherburn, Hickson, Reid, Torres-Rueda, & Bourne, 2017). This development coincided with the rise of so-called 'geospatial sociosexual networking apps' that increase the ease with which participants can find willing sexual partners in their immediate location and on demand, as well as the drugs that go along with it (Stuart 2016; Frankis and Clutterbuck 2017).

Since chemsex is still considered an emerging phenomenon, no reliable prevalence figures exist (Stuart 2016). Generally, however, population studies from various countries have indicated that substance use is higher among MSM than among the general population (Melendez-Torres and Bourne 2016). Research suggests that MSM use stimulants more commonly than non-MSM, and that HIV positive MSM use stimulants more frequently than men who are HIV negative or are unaware of their status. Similarly, using drugs decreases the chances

of using a condom among MSM (Bourne et al., 2015) mephedrone and gamma-hydroxybutyric acid (GHB.

Taking drugs before or during sex is also linked to a higher number of sexual partners, higher levels of high-risk sexual behaviours, and increased STI diagnoses (Pufall et al. 2018). That is not to say that using drugs during intercourse is necessarily problematic: some people do state to be in control of their use and of keeping to pre-determined rules during sex (Bourne et al., 2015). Other studies also note correlations between problematic drug use among MSM and mental health issues, such as anxiety, psychosis, and the inability to have sex without using drugs (Melendez-Torres and Bourne 2016). There is a concern that chemsex could lead to an increase in HIV, Hepatitis C or STI incidence among MSM, however, to date that assumption has not been supported by sufficient evidence (Bourne et al., 2015; Melendez-Torres & Bourne, 2016). It does seem likely that the combination of various high-risk factors contribute to an increased risk, such as: many sexual partners in quick succession; inconsistent condom use; not always serosorting sexual partners; intense and prolonged sexual activity leading to small rectal or penile wounds; injection drug use; and high impact sexual activities (e.g. 'fisting') (Melendez-Torres and Bourne 2016).

As many authors state, there is an urgent need to develop interventions aimed at reducing both drug and sex related harms for this specific target group in a chemsex context (Tomkins et al. 2018; Knoops et al. 2015; Bourne and Weatherburn 2017; Melendez-Torres and Bourne 2016; Stuart 2016). Recently, various harm reduction oriented approaches to chemsex have been described, and both professionals and people involved in chemsex argue in favour of integrating chemsex assessments and referrals into existing care pathways (Knoops et al. 2015a; Pufall et al. 2018; Bakker and Knoops 2018). One example is to provide chemsex services within MSM-friendly sexual health clinics or services, instead of referring men to existing drug services. Some such specialised services have already started emerging in the USA, Australia and the UK (Frankis and Clutterbuck 2017; Knoops et al. 2015a). Recommendations also includes offering direct contact with chemsex users, and providing non-judgmental information on harm reduction and (sexual) health promotion (Adam Bourne, Ong, and Pakianathan 2018). Many

authors stress the importance of writing in a tone of voice that is relatable to chemsex users, using slang terms that are used in the chemsex scene (Bakker and Knoops 2018; Stardust et al. 2018). Dutch harm reduction organisation Mainline has developed a number of physical IEC materials focusing on improving self-control and providing harm reduction tips such as safer injecting practices, hydration and how to deal with mental health issues (Bakker and Knoops 2018). These IEC materials are also distributed to sexual health professionals and to locations where chemsex takes place, such as clubs, bars and saunas. In both Australia and South-Africa, 'safe sex packs' and 'safe drug use packs' (for injecting as well as non-injecting users) have been distributed among MSM by peers during outreach activities (Hugo et al. 2018; Stardust et al. 2018). Several organisations have organised (peer) support groups. In the Netherlands, these are mostly aimed at keeping in touch with the scene as well as the facilitation of peer support, aimed at either active chemsex users or men who have quit chemsex (Bakker and Knoops 2018). An Australian program combines therapeutic elements with a harm reduction peer support model (Burgess et al. 2018). In chapter 5.2 we describe a Spanish programme working with an online intervention for chemsex users.

4.3 Female focused interventions

Compared to men, women face different risks and contexts of drug use. Women experience more stigma, are at a greater risk of exposure to violence, are more under the influence of their partners in their drug use patterns and sexual behaviours, are more defined by their parental role, and are more likely to engage in sex work, thus increasing the risk of exposure to blood-borne infections (Arpa 2017; Bungay et al. 2010a; Limberger et al. 2016) Despite these gender differences, studies and strategies specifically aimed at female PWUD are still underdeveloped, even more so where stimulant use is concerned.

Reports and studies on the needs of female PWUD tend to focus on three main areas: access to care, pregnancy and parenting, and sexual and reproductive rights. The EMCDDA (2018a) best practice portal provides guiding principles on how to respond to these needs, irrespective of the drug of choice. Regarding access to care, guiding principles include having specific services for women which are non-judgmental, supportive, physically and emotionally safe, and promote healthy connections to family members and significant others. Besides, special services should be in place for pregnant and parenting women which use drugs, including obstetric and gynaecological care, care for infectious diseases, mental health, personal welfare, childcare and family support. Women engaged in sex work may need special measures to overcome access to care barriers – such as evening opening hours and mobile outreach.

Low-threshold, user-friendly and gender-tailored interventions are recommended to increase the access to health and social support services among female sex workers who use crack. Those initiatives might also increase their access to reproductive health in general, and to preventive strategies focusing on HIV/AIDS and other sexually transmitted infections (Malta et al. 2008). Female focused interventions reduce harms more effectively for female crack cocaine users than gender neutral interventions. For example, one study found that both female focused and gender-neutral HIV prevention interventions were successful in reducing crack use and high-risk sexual engagement. However, the female-specific intervention had better results in facilitating employment and housing, and in long-term reduction of unprotected sex (Wechsberg et al. 2004). Another study calls for the need to adapt female focused interventions for specific sub-groups of women. The type of stimulants used, routes of administration or combination of drugs, influence women's harms and their response to interventions. For instance, sexual and reproductive health rights (SRHR) interventions were found to decrease behaviours of exchanging sex for drugs or money in women smoking crack. However, the intervention worked better for women wo only smoked crack cocaine than for those women who smoked and injected their drugs (cocaine, heroin or speedball). Those who only smoked crack were also more likely to decrease their drug use (Sterk, Theall, and Elifson 2003).

Besides, harm reduction interventions should take into account the specific context and risk environment for women using stimulants, including

their drug-using partners (Shannon et al. 2011). The International Community of Women Living with HIV (ICW), the International Network of People who Use Drugs (INPUD), and the International Network of Women who Use Drugs (INWUD), advocate for removing any legislation that makes drug use alone the rationale for extracting children from their parents' custody or that seeks to punish women for using drugs during pregnancy. They also promote supporting programmes for incarcerated women, ensuring affordable and evidence-based SRHR services are available, ending stigmatization, and implementing gender-based data disaggregation and increased research (INPUD, ICW, and INWUD 2015).

In the case of pregnant or parenting women who use stimulants, there is a strong focus on reducing harm by reducing or ceasing drug use (WHO 2014). Other harm reduction strategies, however, do exist. For pregnant women using methamphetamines, for instance, some guidelines include improving nutrition, decreasing tobacco smoking, decreasing alcohol and other drug use, promoting dental health and encouraging physical activity, and encouraging early and continuing prenatal care (Wright et al. 2012). In the case of women who are pregnant and use crack, Macedo and Machado (2016) call attention to the need of reducing stigma and enforced actions in social and health services. Coerced policies discourage women who use drugs from seeking comprehensive medical treatment during their pregnancies. Social and health services need to be low-threshold and work to meet the needs of substance-using women (Stone 2015).

Stimulant use during pregnancy often exists together with other detrimental life circumstances, such as poverty, violence, mental health problems, poly-substance use, nutritional deficiencies, inadequate health care and stressful life experiences. Engaging women into prenatal care in a nearby community clinic grants access to resources and referrals to deal with these risks for both mothers and their families (Wright et al. 2012). In terms of treatment, both the EMCDDA (2018a) and the WHO (2014) do not recommend pharmacotherapy for pregnant women who are dependent on ATS or cocaine .

Women who use stimulants and engage in sex work face specific risks, which must be considered separately. Female sex workers who use drugs often engage more in risky behaviours (e.g. unprotected sex with multiple partners) and suffer physical and sexual violence from clients. Besides, many do not have good access to health services or social support. As for methamphetamine, its use can increase libido and dehydration, causing women to have sexual intercourse for longer periods with a higher risk of vaginal or oral injuries. So associated sexual practices are linked to elevated risk for HIV and other STIs (McKenna 2014). In female sex workers who use crack frequently, lip and mouth injuries and frequent unprotected oral sex create a potential route of infection (Wallace et al. 1997). Logan and Leukefeld (2000) found that both the crack using women who exchange sex for drugs or money and those do not engage in sex work/exchange, were found to have frequent unprotected sex. Although not addressed in a separate case study chapter, the interventions in chapter 5.1 and 5.4 both also offer female specific services, as is described in these chapters.

4.4 Drug consumption rooms

Drug consumption rooms (DCRs) are professionally supervised healthcare facilities where PWUD can use drugs in safer and more hygienic conditions (Hedrich, Dubois-Arber, and Kerr 2010). The three primary goals of DCRs are to reduce morbidity and mortality by providing a safe environment and training PWUD in safer use, to reduce public drug use and improve public amenity in open drug scene areas, and to promote access to social, health and drug treatment facilities (EMCDDA 2018c).

In 1986 the first legally sanctioned DCR was established in Switzerland. During the 1990s, Germany, the Netherlands and Switzerland were the first countries in the world that started offering this service. Although it remains controversial, 80 legally sanctioned drug consumption rooms are currently being offered in eleven different countries (EMCDDA 2018c). The vast majority (78) of these facilities are located within Europe. The only two countries outside of Europe that offer DCR services are Australia and Canada, but debates on opening a DCR are currently going on in many more countries.

These discussions can and often do go on for a very long time. For example, in Denmark, the first DCR was opened in 2012 after more than 20 years of debate. Local activists from Copenhagen, who were running an unofficial DCR, fought for over two decades before a new government finally adapted the policy allowing the legal establishment of a DCR in their country (Houborg and Frank 2014). Both Portugal and Ireland are planning to open DCRs in the near future, and in Belgium a DCR feasibility study has been presented in early 2018 (EMCDDA 2018c).

Public opposition often centres around the conviction that DCRs may attract open drug scenes and public nuisance. In addition, acknowledging widespread drug use is usually considered to be politically risky (Schäffer and Stöver 2014). However, a recent literature overview presents evidence that DCRs in fact do not lead to increases in substance use and crime (Belackova and Salmon 2017).

A typical drug consumption rooms provides its service users with: 'sterile injection equipment; counselling services before, during and after drug consumption; emergency care in the event of overdose; and primary medical care and referral to appropriate social healthcare and addiction treatment services' (EMCDDA 2017c). In two global DCR inventories, in 2014 and 2017, around 90% of DCRs confirmed offering referrals to care/treatment facilities, provision of needles and other paraphernalia, and basic facilities such as coffee and tea (Woods 2014; Belackova et al. 2018). There are three different forms of drug consumption rooms that are distinguished as follows: integrated, specialised and mobile. Integrated facilities are part of a broader interlinked network of services and are the most common type, specialised DCRs only offer services directly related to supervised drug consumption, and mobile DCRs offer limited but geographically flexible services (Schäffer and Stöver 2014; EMCDDA 2018c).

Although DCRs mostly target PWID, they increasingly focus on people who smoke or sniff their drugs (EMCDDA 2017c). In a 2017 inventory among 43 DCRS, 41 facilities offered spaces for safe injection, 31 (also) offered spaces for smoking, with 22 DCRs (also) facilitating spaces for sniffing. 34 of these DCRs allowed for at least two different means of

drug administration (inject, snort or smoke), either in separate spaces or in the same room (Belackova et al. 2018). In this same inventory, stimulants – including (meth)amphetamines, crack cocaine, cocaine, and cathinones – seemed to be the substances most commonly used, irrespective of route of administration. Almost just as common is the use of heroin, followed by a combination of opiates and stimulants (*speedballing*). Less popular substances among people that visit DCRs were other opioids, pharmaceuticals and o*ther drugs* (Belackova et al. 2018).

The evidence supporting DCRs for PWID is well-established, in large part thanks to scientific studies that accompanied the opening and development of DCRs in Vancouver (Canada) and Sydney (Australia) (EMCDDA 2017c). There is evidence that DCRs lead to reductions in risk behaviours related to infectious diseases, overdose fatalities, public disorder, as well as to an increased uptake of treatment services (Strathdee and Navarro 2010). There is less concrete evidence on DCRs for people who smoke drugs, although several studies have shown that supervised smoking rooms are able to reduce harm and risky behaviour in users who smoke their drugs (Jozaghi, Lampkin, and Andresen 2016; Collins, Kerr, Kuyper, et al. 2005; McNeil et al. 2015; DeBeck et al. 2011). Harms, such as the spread of infectious diseases, mental health problems and the exacerbation of social problems, may be reduced through interventions offered at the DCRs, such as the prevention of pipe sharing, distribution of safer smoking kits, education on safer drug use, access to health- and social services, and the stimulation of self-control.

Many of the benefits of supervised injection facilities also apply to facilities for smokers: they provide a safe, non-rushed environment; users have access to sterile equipment; ideally have access to other health and social services (including psychosocial support, medical services, addiction treatment etc.) (Voon et al. 2016). DCRs have strong potential to reach hard-to-reach PWUD (EMCDDA 2018c). The DCR can connect them to health and social services, such as healthcare, drug treatment, referrals to legal services, housing programmes. In such a way, DCRs also address the harms associated with the broader risk environment (DeBeck et al., 2011; McNeil, Kerr, Lampkin, & Small, 2015; Shannon et al., 2006). A recent literature overview on DCRs (2017)

summarizes six evidence-based benefits of DCRs: reaching high risk PWUD, preventing overdoses, enhancing safer drug use practices, decreasing public drug use, facilitating access to care and social services, and preventing the transmission infectious diseases (Belackova and Salmon 2017). Moreover, particularly DCRs that provide spaces for both injection and inhalation, are likely to facilitate a transition from injection to less risky forms such as smoking. This may positively impact the quality of life and improve the health of PWUD (Voon et al. 2016; Strathdee and Navarro 2010; McNeil et al. 2015). In chapter 5.7 we describe three Dutch programmes offering Drug Consumption Rooms.

4.5 Self-regulation

The theory of self-control was developed by Gottfredson and Hirschi in 1990 and has since become an important theory in explaining criminal behaviour, but also other behaviours such as gambling and substance use. Self-control or self-regulation is defined as the psychological process through which people control their response to thoughts, feelings, impulses, and needs (Baumeister, Vohs, and Tice 2007). People with impaired self-control are generally more impulsive, more likely to take risks, and they are less able to resist the immediate gratification offered by easy, immediately pleasurable effects offered by substances. This is partly because they are less able to consider the long-term consequences of their actions (Ford and Blumenstein 2013). Impaired self-control makes it harder to resist consuming a substance in the first place or to consume a regulated or pre-defined amount. There are many studies on impulsivity and substance use, although the majority of the research has been done on animals and adolescents. These studies generally show that impulsivity is related to developing problematic substance use patterns, such as compulsive or binge use, or addiction (Ford and Blumenstein 2013). Besides, higher scores on measures of self-regulation are associated with lower alcohol use problems (Chavarria et al. 2012). Substance use can also trigger impulsive actions, making it even harder for PWUS to gain control over their use. Self-regulation has been compared to a *muscle*, in the sense that using it too frequently may lead to decreased performance at the end of

the day, while over time, practicing self-regulation makes people better equipped to do so (Baumeister et al. 2006). Self-regulation has been shown to play a role in in becoming and staying abstinent (Ferrari, Stevens, and Jason 2009).

The (brain) disease model of addiction, which states that addiction is a chronic, relapsing brain disease, resulting from prolonged effects of drugs on the brain, has by and large disregarded the role of the (risk) environment (Grund 2017; Zuffa and Ronconi 2015). According to this model, changes in brain structure eventually (and some would argue, inevitably) lead to loss of control and dependence, characterised by compulsive drug seeking and use, despite harmful consequences (Leshner 1997; Volkow and Li 2004; Volkow 2014). The disease theory is contradicted by both the wide variation in drug use patterns and the varying levels of success people have in controlling or regulating their drug use (Grund, 2017). This goes for people who use opioids but also holds true for people who use (crack) cocaine, amphetamine and methamphetamine (Cohen & Sas, 1993; Decorte, 2001; Grund, 1993; Hart, 2013; Zinberg, 1984). Supporting self-regulation and users' strategies to gain or maintain control over their drug use ties in with a harm reduction approach that aims to regulate drug use and empower users (Forum Droghe and Transnational Institute 2014). It also ties in with harm reduction's *bottom up* approach, which emphasises users' ability to control their use and reduce their risks (Zuffa and Ronconi 2015).

The self-regulation approach should focus on empowering users' skills and competencies, supporting communicative structures among PWUD, and promoting cultures of safer use. Some of the methods that PWUD use to apply control to their use include: setting *rules* for their use (e.g. amount or frequency of use); the set (e.g. only using when feeling well); the setting (e.g. using only with friends, not when at work) (Forum Droghe and Transnational Institute 2014). Various strategies are being employed by PWUD themselves even if they are not necessarily convinced of the risks, such as: always carrying their own materials; refusing to share; assessing risks visually (e.g. does someone have visible wounds); or asking people if they have HIV or HCV (Boyd, Johnson, & Moffat, 2008; Poliquin et al., 2017; Ti et al., 2012). It then follows that a model of self-regulation should aim to develop mechanisms

of control and, with the close involvement of peers, help to circulate these among PWUD (Zuffa 2014). Finally, such a model should also facilitate optimal environmental conditions to help PWUS maximise their ability to gain control, while minimising negative influences.

Mindfulness-based interventions (MBIs) include a range of different approaches such as mindfulness-based stress reduction and mindfulness-based cognitive therapy. All MBIs are characterised by systematically developing the skill to pay attention to the present moment with a non-judgmental and accepting attitude (Chiesa and Serretti 2014). MBIs have increasingly become popular for myriad disorders, and several studies indicate they may be effective in reducing substance use, among others for cocaine and methamphetamine (Zgierska et al. 2009). In a recent systematic review, Chiesa & Serretti (Chiesa and Serretti 2014) summarise how MBIs may help for problematic substance use: by learning to be non-judgmental toward, and more accepting of, distressing events, and by changing one's (attitude towards) thought patterns, PWUD may learn to more effectively deal with unpleasant emotional situations, reducing the need to take a substance in order to suppress unwanted emotions (Chiesa and Serretti 2014). MBIs may also assist in staying present with whatever one experiences instead of escaping it, however unpleasant, and help in becoming more aware of processes that may lead to using and observing these thoughts and feelings from a distance (Brewer, Elwafi, and Davis 2013). Finally, there is evidence that MBIs can be effective in treating various mental health disorders – including stress, anxiety, and depression. These are all closely related to problematic substance use and relapse. This would also imply that MBIs could be especially helpful for PWUD with comorbid mental health issues (Zgierska et al. 2009). In the second part of this report, we describe a South African programme working with contemplation groups stimulating self-regulation.

4.6 Housing first

The problematic use of stimulants has been associated with poverty, unemployment, incarceration, homelessness and unstable housing (Grund et al. 2010). Strategies to deal with these issues thus have the capacity to address several of the harms of problematic stimulant use (WHO 2011). Homelessness is addressed through housing first interventions. Housing first seeks to move people into permanent housing as quickly as possible. Permanent and stable housing is emphasised as a primary strategy for the care of homeless people, people with mental health problems, and people who use drugs. This contrasts with *treatment first*, which demands people to go through a series of stages, such as becoming abstinent, before they are *housing ready* (Busch-Geertsema 2013). The eight principles of housing first are: 'housing as a basic human right; respect, warmth, and compassion for all clients; a commitment to working with clients for as long as they need; scattered-site housing in independent apartments; separation of housing and services; consumer choice and self-determination; a recovery orientation; and harm reduction' (Busch-Geertsema 2013).

Basically, adequate supply of stable housing is in itself a harm reduction intervention (Pauly et al. 2013). Living in unstable housing[1] affects how likely people are to be exposed to drug use, use drugs themselves, how readily they access and stay in treatment, and how likely they will be incarcerated for drug use (Zerger 2012). Unstable housing has also been associated with increased and high risk drug use and risky sexual behaviours (Cheng et al. 2015, 2014) as well as with recent injection drug use, including cocaine and methamphetamine injection, and high levels of crack smoking (Kate Shannon, Ishida, Lai, et al. 2006). Living in the streets has been associated with a significantly increased likelihood of sharing instruments for drug use, such as crack pipes (Boyd et al. 2017). Homeless people are forced to use their drugs in public, and smoking crack in public – in contrast to privately at home – is linked to an increased risk of overdose or transmission of HIV, HCV and other infectious diseases (Voon et al. 2016).

Safe, affordable and low-threshold social housing has proven to be crucial in reducing substance-use

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1   Unstable housing can be related to having difficulties in paying the rent, eviction threats, frequent moves, crowding, or staying with family or friends. In the studies mentioned here, unstable housing was broadly defined as living doubled up with friends or family, in shelters, on in the streets, while homelessness was broadly defined as living in shelters or in the streets.

related harms and improving quality of life and social inclusion (Boyd et al. 2017). A 2011 study showed that housing first clients were significantly less likely to drop out of services, in comparison to *treatment first* clients. They were also far less likely to (problematically) use substances, even though in housing first they were not required to stop using drugs as they were in the *treatment first* approach (Padgett et al. 2011). Another study compared the effects of treatment on people who received housing under the condition of being in treatment and remaining abstinent, to treatment effects on people who only received housing first (Tsemberis, Gulcur, and Nakae 2004). Housing first participants experienced significantly higher levels of autonomy in the programme and were more likely to maintain their house after one year of treatment. Furthermore, even though the first group had higher levels of treatment participation (as this was obligatory), the study found no significant difference on drug use between the two groups.

Programmes based on housing first principles have shown successful results in many parts of the world. A study evaluating housing first projects in ten European cities found that most people, even those who use drugs excessively, could retain their house over a long period of time (three or more years). Many people who used substances problematically said they had decreased their use thanks to housing. Participants reported a higher quality of life, reduced stress and an increase in personal safety. Besides, housing provided the basis for stability, daily routines, privacy, and a less stigmatised life (Busch-Geertsema 2013).

Having stable housing has also been found to help reduce drug consumption in Canada. A study found that 74% of the participants of housing first programmes said their use had decreased since they moved into housing; 33% had quit using drugs completely, and 41% had decreased their use (Toronto Shelter 2007). In Brazil, Braços Abertos, a programme offering housing to PWUD helped 65% of participants to decrease their crack consumption (Rui, Fiore, and Tófoli 2016). In the programme featured in this report as a case study (Atitude), 38% of participants said they quit crack use after participating in the programme (Luis Ratton and West 2016). Others mentioned that the programme has helped them to have better control over their

use (OSF 2017). Housing first was also evaluated positively in the Netherlands, helping youth with problematic drug use and psycho-social behaviour to reduce their drug consumption (Konijn, de Vos, and Luchsinger 2015). Housing first programmes helped participants to develop healthy routines, healthier eating and stable sleeping patterns, both in the Netherlands (Konijn, de Vos, and Luchsinger 2015) and in Brazil (Rui, Fiore, and Tófoli 2016).

Finally, studies have shown that having a stable house can encourage people to choose less harmful routes of drug administration. In a study among young methamphetamine injectors in Canada, housing was found to be an important factor in facilitating cessation of injection (Boyd et al. 2017). Similarly, studies in the US and India found a stable housing situation to be associated with decreased drug injection (Steensma et al. 2005; Shah et al. 2006; Mehta et al. 2011). In chapter 5.1 we describe a Brazilian programme working with housing first.

4.7 Substitution

Substitution is defined as the conscious choice to replace use of one drug with another, based on 'perceived safety, level of addiction potential, effectiveness in relieving symptoms, access and level of acceptance' (Lau et al. 2015, 654). Over the years, researchers and PWUS alike, have looked for substances that can support maintenance therapy, reduce stimulant use or reduce the adverse effects associated with its use, similar to the role of methadone and buprenorphine for people who use heroin. Much like substitution for opioids, the effective implementation of substitution programmes for stimulants may be challenged by diverse legal frameworks, which at times allow for the substituting substances and at times not.

4.7.1 Plant based substitutes

People have reported using several different plants to combat a number of adverse symptoms of stimulant use. Leaves of the shrub Khat (*Catha edulis*), which are traditionally chewed by men in the Horn of Africa and Yemen, is one such example. Its principle psychoactive ingredient is the alkaloid cathinone, chemically similar to amphetamine and known to produce amphetamine-like effects (Kalix 1981). Cathinone is the chemical basis of

the cathinone-class, which includes mephedrone and methcathinone. Some view it as a potential herbal substitute for stimulants such as cocaine and amphetamine due to its milder effects (Klein, Metaal, and Jelsma 2012).

The coca plant (*Erythroxylum coca sp*) is native to the South-American Andes mountain range; the alkaloid cocaine is extracted from its leaves. The coca leaf carries a negative connotation due to its association with the illicit cocaine trade. Nevertheless, medical doctors have experimented with its use as a milder alternative for people who use cocaine. This substitution practice has been documented in Peru, Bolivia, and Brazil, but still has inconclusive results (Henman and Metaal 2009, 2014; Harris 2011).

Salvinorin A is the principle psychoactive compound found in the hallucinogenic plant *Salvia divinorum,* native to the Oaxaca mountain range in Mexico. Although its practical application remains limited and largely unknown, a review of preclinical and clinical studies between 1999 and 2014 suggests that it may carry a therapeutic potential for the treatment of 'psychostimulant-related disorders' (dos Santos et al. 2014).

Some PWUS choose to use plant-based stimulants that are legal in their country (such as ephedra, betel, kava, kratom, and others) over stimulants that are not. This can also be considered a harm reduction practice, since it attempts to avoid the social and/or legal risks associated with the consumption of controlled substances (Wiecko, Thompson, and Parham 2017).

A growing number of studies suggest that cannabis – in some cases smoked together with cocaine – may be effective in reducing craving for, as well as (partly) substituting cocaine use (Labigalini, Rodrigues, and DaSilveira 1999; Lau et al. 2015; Lucas et al. 2013, 2016; Reiman 2009; Socías et al. 2017; Gonçalves and Nappo 2015; Ribeiro, Sanchez, and Nappo 2010). Experiences of users demonstrate that cannabis can help minimise various side effects of crack/cocaine consumption, in particular psychological harms such as anxiety, aggression and paranoia (Fischer, Kuganesan, et al. 2015). Cannabis also reportedly alleviates discomfort during withdrawal periods.

One study in Jamaica describes female PWUD who frequently or regularly smoke cannabis cigarettes or *spliffs*, or those who mix cannabis with crack, in so called *seasoned spliffs*. The study reports benefits of cannabis in preventing paranoia and loss of appetite. Also, cannabis appears to soften the effects of crack cocaine, reduces craving and withdrawal, and decreases engagement in risky behaviours, helping to regulate crack use (Dreher 2002). Similarly, in Brazil, among people who use freebase cocaine, the consumption of cannabis is considered a form of protection against negative aspects of crack cocaine use; for instance it is used as a sleeping aid and to overcome eating disorders, thereby increasing PWUS quality of life (Andrade et al. 2011; Gonçalves and Nappo 2015; Ribeiro, Sanchez, and Nappo 2010). A 2018 study in Brazil followed 62 people who use freebase cocaine over the course of four weeks, looking at the role of cannabis on craving for crack cocaine. The authors found that the use of cannabis was strongly correlated with decreases in anxiety and also found that greater use of cannabis was related to lesser experienced craving (Escobar, 2018). In 2017, a longitudinal survey was conducted among PWUD in Vancouver, Canada, demonstrating the effectiveness of intentional cannabis use in reducing the frequency of crack cocaine consumption (Socías et al. 2017). Two other surveys among Canadian and American medical cannabis patients report that many patients specifically opt for cannabis as a safer substitute for alcohol, prescription drugs, and illicit drugs such as cocaine (Lucas et al. 2013, 2016; Reiman 2009).

Some studies have also demonstrated the effects of cannabis substitution for other stimulants. For example, mephedrone users have reported consuming cannabis to ease the mephedrone comedown, typically perceived as uncomfortable (Van Hout and Brennan 2011). It is also suggested that specific cannabinoids compounds such as CBD are responsible for cannabis' therapeutic potential in relation to reducing negative aspects of stimulant use, as CBD and related compounds are known to have anxiolytic, anti-psychotic, and anticonvulsant properties which may in turn help PWUS sleep and eat better, and reduce impulsive, potentially risky behaviour (Fischer, Kuganesan, et al. 2015; Pedrazzi et al. 2015).

However, despite existing positive results from some cannabis substitution studies, there are potentially

negative impacts from cannabis use, as it provides its own (mental) health risks. For instance, in one study, several respondents mention experiencing physical or mental health issues after cannabis use, even though many of the respondents preferred cannabis over alcohol and other illicit drugs, because they perceive it to have fewer side-effects (Lau et al. 2015). Another study showed that cannabis may induce – rather than reduce – craving for cocaine in people who use both cocaine and cannabis problematically (Fox, Tuit, and Sinha 2012). Besides, cannabis remains to be an illicit substance in the vast majority of countries thus complicating the formalisation of cannabis substitution, causing potential negative implications and legal consequences for PWUD, professionals and services.

4.7.2 Pharmaceutical agonist and antagonists

Over the years, there have been numerous attempts to find a pharmacological agent that can assist (or treat) people with stimulant dependence. Most, if not all, research has focused on amphetamine, methamphetamine and cocaine dependence. Separate bodies of research have looked at antagonists on the one hand, and agonists on the other.

With antagonists, the idea is to find a drug that blocks stimulants' desired effects, which theoretically would lead PWUS to reduce or quit their use. To date, no substance has yielded clinically significant results, and some substances have even proven to be counter effective (Stoops and Rush 2013).

The idea behind (supervised) agonist therapy is to replace the illicit drug with a pharmacologically similar drug that has comparable effects but can be used more safely. Ideally, the agonist has a longer effect, less impairment/intoxication, and a lower addictive potential (Shearer 2008; Nuijten 2017; Castells et al. 2016). This approach can be applied both to treatment modalities aiming at complete abstinence, as well as for harm reduction purposes, allowing PWUS to gain more control over their use, reducing use-related harms, and improving quality of life. This approach has proven effective for users of opioids (Nielsen et al. 2016) and tobacco (Stead et al. 2012).

A great number of clinical trials have assessed the safety and efficacy of various pharmacological interventions – including various classes of antipsychotics, antidepressants and many others – to help treat amphetamine, methamphetamine and (base) cocaine dependence, with very limited results.

A 2016 Cochrane metareview on the evidence of substitution treatment for cocaine dependence using other stimulant drugs (e.g. (lis)dexamphetamine, methylphenidate, modafinil, methamphetamine, and amphetamine) demonstrated very little impact on treatment retention when compared to placebo, and some evidence that people who use cocaine stayed abstinent longer when compared to placebo. Dexamphetamine was considered to be a potentially promising agonist for cocaine dependence treatment, especially for poly-users of heroin and cocaine (Castells et al. 2016). No evidence was found for the clinical use of direct dopamine receptor agonists (DA-agonists) that don't have any psychostimulant properties (such as amantadine, bromocriptine, L-dopa, and pramipexole) for people who use cocaine (Minozzi et al. 2015). Indirect dopamine-agonists that do have cocaine-like effects (e.g. bupropion, dexamphetamine), on the other hand, did seem to have some promise as a substitute substance for cocaine dependence (Castells et al. 2016).

Another metareview reviewed the available literature for both amphetamine and cocaine treatment, comparing dopamine releasers (DRAs, e.g. amphetamine, methamphetamine) with dopamine reuptake inhibitors (DRIs, e.g. methylphenidate and bupropion). The review showed that DRIs are more effective than DRAs in treating amphetamine use, whereas DRAs seem more effective in reducing cocaine use of cocaine. Specifically, methylphenidate significantly reduced amphetamine but not cocaine use, whereas (dex-)amphetamines did significantly reduce cocaine use. Interestingly, there was no evidence for the effectiveness of using dex-amphetamine to reduce amphetamine use (Stoops and Rush 2013).

Finally, there is some evidence from two recent trials that modafinil may be effective as a substitute for cocaine, although earlier trials sometimes failed to show positive impact (Kampman et al. 2015; Morgan et al. 2016). The same inconsistent results are reported from studies looking at the use of methylphenidate for cocaine use (Nuijten 2017). It seems likely that the effectiveness of most agonist

agents for the treatment of stimulant dependence seem to be dependent on the particular stimulant they intend to replace, as well as on dosing, and the specific subpopulation of PWUS (whether they're single or poly drug users, for example) (Nuijten 2017).

4.8 Outreach & peer-based interventions

'Outreach is a client-oriented and community-based harm reduction method that makes contact with and provides health and social services to people who use drugs in their natural settings or territory' (Korf et al. 1999). Outreach helps to reach people who do not come to harm reduction services themselves. It is an entry point to services and into the community (International HIV/AIDS Alliance 2013). Many PWUS do not seek help from public health services themselves. Therefore, outreach work is strongly advised to increase access to care for this population (Horta et al. 2011; Souza and Carvalho 2014). They can 'bridge' two different cultures, operating as a sort of translation between users' language and needs and professionals' language and criteria. Outreach workers can even accompany users to services to 'bridge' more effectively (Souza and Carvalho 2014). Sometimes, outreach work is carried out by multi-professional teams in mobile units. Multi-professional teams can be formed by peer outreach workers, nurses, psychologists, social workers, and physical educators. Mobile units are typically vans which contain basic nursing and care equipment from which the team can provide harm reduction services such as paraphernalia distribution, rapid HIV testing, counselling, primary care for wounds, etc. These services can also promote access to health care, and encourage bonding between PWUS and service providers (Macedo and Machado 2016; Engstrom and Teixeira 2016).

Outreach done by peers effectively engages PWUS (Jozaghi, Lampkin, and Andresen 2016) and other marginalised and hard-to-reach populations (Jozaghi and Reid 2014; C. Campbell and Mzaidume 2001). Evidence shows that peer education – in a supportive non-stigmatising and non-incriminating environment – is the most effective way to share new knowledge and skills among PWUD. Peers are trusted more easily, because they share norms,

experiences, language and background. This makes it easier to convey honest harm reduction education and information (Latkin 1998; Korf et al. 1999). Peer outreach is particularly effective for safer drug use education and distribution of paraphernalia (Jozaghi 2014).

A US study, for instance, showed positive results for peer-based interventions for people who used crack cocaine and recently left treatment services. Outreach work helped reduce the frequency of crack use and sexual risk behaviour (Cottler et al. 1998). Another study showed that peers were able to reduce the risk of contracting an infectious disease such as HIV, HCV, and TB among people who smoke crack cocaine and/or methamphetamine (Jozaghi, Lampkin, and Andresen 2016). Peer-based outreach projects stimulate social inclusion, encourage knowledge sharing among PWUS, and strengthen prevention strategies. For example, they may increase the PWUS acceptance of projects such as safer crack-smoking kits distribution (Domanico and Malta 2012). Furthermore, peers are good at identifying new trends and responding to them quickly and effectively (Poliquin et al. 2017).

Peer-based service delivery through outreach is an attractive addition to existing public health programmes because 'it extends the temporal, spatial and social reach of programmes' (Strike and Kolla 2013, 10). Peer programmes can assist PWUD at times and locations not served by existing programmes and extend harm reduction reach to those people who are reluctant to attend other programmes (Strike et al. 2002). Besides, formal employment of peers helps to empower individual PWUD and their community as well as reducing their own drug-related harms. Increasing self-confidence and self-efficacy, helps PWUD to advocate for human rights and stimulates sustainable change in the drug-using community (Forum Droghe and Transnational Institute 2014).

Outreach work can also support PWUS to avoid starting injecting or encourage people who inject to transit to non-injection routes of administration. This can be done through informing people about the risks of injecting or about safer methods to use (Pinkham and Stone 2015; United Nations Office on Drugs and Crime 2017). In one study, people who injected methamphetamine frequently mentioned

that having harm reduction information was helpful in moving away from injecting to smoking the drug (Boyd et al. 2017). People who have rising tolerance and increased frequency and dose of using, as well as those who associate with active injectors, and witness stimulants being injected are at higher risk of injecting their drugs. Educating people about these risks is an effective preventive outreach measure (UNODC, n.d.). The distribution of paraphernalia, such as silver foil, safer snorting kits or gel capsules, is also a recommended strategy to prevent transition to injecting drugs (United Nations Office on Drugs and Crime 2017). Smoking is generally considered a better route than injection, as there is lower transmission risk of infectious diseases such as HIV and HCV, and there is lower risk of overdose and bacterial infections (Des Jarlais et al. 2014). In the Czech Republic, the distribution if empty gelatine capsules was successful in reverting injection of amphetamines to swallowing among some PWUD (Mravčík et al. 2011; Pinkham and Stone 2015). This simple and low cost approach has contributed to reducing risks of bloodborne diseases and of smoking with toxic materials (Pinkham and Stone 2015). However, alternative routes may carry risks on their own, as some studies suggest long-term oral drug use may cause gastric ulcers (Mravčík et al. 2011) and long-term smoking may cause serious lung diseases (Terra Filho et al. 2004; Wolff and O'Donnell 2004) several medical articles have given special emphasis to pulmonary complications.

The WHO advocates for providing culturally sensitive and clear messages to people who use ATS when doing street-based work. These outreach messages should be both evidence-based and relevant for their context. Important and effective messages are: decrease quantity and frequency of ATS use, drink water, improve diet, get adequate rest, employ strategies to help control drug intake, monitor one's own behaviours, and do not use drugs alone. Other counselling messages include avoiding mixing ATS with other licit or illicit drugs, avoiding injection, and using condoms (WHO 2011). These recommendations apply to people who use other stimulants as well. In chapter 5.6 we describe an Indonesian programme working with an outreach intervention.

4.9 Drop-In Centres

Drop-in centres are an important low-threshold harm reduction service that is offered all throughout the world. Peer-support interventions are often an important component of drop-in centres (DICs) (Wilson 2015). Although extremely varied in structure and services on offer, drop-in centres typically offer social support in the community, particularly to marginalised groups, such as sex workers, homeless people and PWUD (Hall and Cheston 2002). DICs are also defined according to three common characteristics: they are responsive and flexible to the needs of the community; they respect service users' autonomy in how they want to live their lives and the changes they want to make; and they take a holistic approach considering all life needs such as housing, food, personal hygiene and meaningful activities. In practice, this means that DICs offer an informal social setting, responding to some basic needs (e.g. food, shelter from the cold, shower and clean clothes) and offer some additional services. These services can be as basic as offering an opportunity for social contact in a safe environment, or offering (psychosocial) support to improve well-being or work on life changes (Paul Dowling Consulting 2007). Drop-in centres can provide vulnerable people – be they PWUD, sex workers or homeless people – with a safe and supportive environment, while stimulating them to make use of wider community resources or make changes in their lives (Hall and Cheston 2002; Paul Dowling Consulting 2007).

It is recommended that DICs always be located near the PWUD community, and that members of the community be involved in the running of the programme. Community members should consult on the location, which services to offer, staff needed and the servicing hours. (UNODC et al. 2017b). Moreover, careful attention must be paid to engagement with the neighbours and local advocacy to ensure acceptance and support for the DIC in the neighbourhood (UNODC et al. 2017b).

A 2015 review on the impact of drop-in centres found them to contribute to a general improvement of overall wellbeing and health as well as 'a range of benefits including reduced drug use, and reduced exchange of sex for drugs, as well as improvements in social participation/engagement, mental health,

days housed (although no improvements securing permanent housing were found) and access to sexual and reproductive health services' (Wilson 2015, 4). An older study on a UK-based DIC stressed how individual service users experience this *space of care* in differing ways. Overall, however, the DIC 'played an important role for a significant minority on the estate, functioning as a place where they could meet others, find a listening ear, access particular advice and information services and, for some, attain a degree of distance from their home environments' (Conradson 2003, 520). In chapter 5.5 we describe a Uruguayan programme offering a drop-in centre.

4.10 Drug checking

Where most classical harm reduction interventions (such as needle and syringe exchange and drug consumption rooms) largely aim at problematic, marginalised or dependent PWUD, harm reduction measures for recreational or unproblematic PWUD – who often use stimulant-type drugs in nightlife settings – fell behind (Brunt et al., 2017). The risks and harms associated with this kind of drug use are different. For instance, the illicit status of these substances results in unknown dosages and contents of pills, tablets, powders or liquids, increasing the risk of overdose. In response, drug checking was developed as an additional harm reduction measure (Spruit 2001).

Implementing drug checking services often requires overcoming legal challenges, such as being granted a license to possess and work with scheduled substances. Many countries do not accept *drug checking* as a valid argument to issue an exemption (Brunt et al. 2017). Scientific research can be a reason to issue a license. The world's first drug checking system – the Drug Information and Monitoring System (DIMS) – was founded in the Netherlands in 1992. Initiated as a scientific project to monitor drug markets (e.g. dose, composition, adulterants and availability), it has since evolved into a nationwide system of testing facilities, embedded in prevention and addiction care institutes (Brunt & Niesink 2011). Other drug checking systems have since been established in other European countries, such as Austria, Switzerland, Belgium, Spain, Portugal and the UK (Brunt, 2017; Brunt et al., 2017).

Drug checking takes different forms. In the Netherlands, a nation-wide network of stationary testing facilities – hosted by addiction treatment facilities – performs basic tests and collects samples to be forwarded to a centralised agency for more extensive laboratory testing. In some countries, mobile laboratories are used for on-the-spot testing, such as at dance events and festivals. Energy Control in Spain also accepts drug samples sent by mail (Brunt, 2017). In addition to the different settings in which drug checking services operate, the methods and analyses used vary as well. The accuracy and reliability of results depends on the method used, and consequently, the extent of harm reduction as well (Brunt 2017). Brunt describes these differences succinctly: 'Simply put, do you merely want to demonstrate the presence or absence of a main component in a drug sample or do you want to provide quantitative information about all compounds in a drug sample to a consumer?' (Brunt, 2017: 8).

There is no conclusive answer as to which currently available technology is most suitable for drug testing as a harm reduction intervention (Harper, Powell, and Pijl 2017). Factors to consider include whether the techniques available also quantify the substances present in testing samples, but also more practically, whether sufficient financial and human resources are available. Techniques range from simple and inexpensive (but inaccurate) colorimetric reagents or microcrystalline tests, to more sophisticated techniques such as liquid and gas chromatography; ion mobility, infrared, and Raman spectrometry; X-ray diffractometry; and thin-layer chromatography, among many others (Brunt, 2017; Harper et al., 2017). From a cost-benefit perspective and for harm reduction purposes, Harper et al. (2017) recommend handheld IR or Raman spectroscopy. In addition, Brunt (2017) mentions the option of quantification using Fourier transform infrared spectroscopy, which is used in the Netherlands.

As mentioned, there are several ways in which drug checking can contribute to harm reduction. It can facilitate reaching and informing young PWUD or people who use NPS. These groups have often never been in touch with prevention services before, and can be hard to reach with traditional and broad prevention messages (Brunt, 2017; Fernández-Calderón et al., 2014; Gamma, Jerome, Liechti, & Sumnall, 2005; Giné et al., 2017a). In case of hazardous adulterants

or dangerous misrepresentations of substances, drug checking services can create targeted and timely public health responses and issue specific health warnings. Many (young) users are distrustful of official governmental prevention messages. They may be more inclined to believe - and be persuaded by - personal contact with people providing tailored harm reduction advice, based on scientific drug sample tests (Brunt 2017; Giné et al. 2017b). In some cases, drug checking services may lead to individuals deciding not to use if their sample has proven to contain unwanted or unknown substances (such as NPS as adulterants of commonly used drugs such as MDMA or LSD), or hazardous adulterants (Brunt 2017; Fernández-Calderón et al. 2014; Giné et al. 2017a; Martins et al. 2017). Some critics argue that drug-checking services can be unreliable and provide a false sense of security, since the absence of hazardous adulterants does not guarantee that use itself is free of harms. However, some of the criticism may be countered by using advanced drug checking tools in combination with the provision of prevention and tailored harm reduction education, including information of the risks of use and of mixing substances (Brunt 2017).

On a larger scale, using information obtained from drug checking services, spreading objective information on the health risks of specific new substances can create awareness among both PWUD as well as among those selling the substances. Accessible and up-to-date online databases and easy-to-read drug information can inform PWUD and promote responsible use strategies (Móró 2014). Examples include websites such as Erowid, TripSit.me, Bluelight.org and the RedNet database. Drug checking and proper drug identification can also discourage (internet-savvy) users from consuming these drugs, and even result in the removal of these substances from the market (Brunt, 2017). This has been observed online, as well as in festival settings, with users reporting their intention to not consume the checked substance, when their sample contained adulterants or proved to be a different substance altogether (Martins et al. 2017). In addition, nation-wide warning campaigns about specific samples (such as ecstasy pills containing the much more harmful substance PMA instead of MDMA, or purported cocaine samples actually being heroin instead) have had similar effects, potentially saving lives (Brunt et al. 2017). That is not to say that all users follow up on their intentions, or that providing information will always lead to changes in behaviour.

Lastly, drug checking services can play an important role in the monitoring of drug trends, by obtaining data directly from users, including data on consumption patterns, experiences, side effects, user practices etc. (Giné et al. 2017b). This is especially useful in an era where new and more potent novel psychoactive substances appear on the market with rapid succession (Barratt and Ezard 2016; Brunt 2017; Giné et al. 2017b). Drug checking services can even be used to monitor non-traditional and hard-to-reach markets, such as those on the *dark web* (van der Gouwe et al. 2017)and ii, making it possible to keep track of a rapidly evolving market and implement specific prevention, education and harm reduction interventions (Brunt et al., 2017).

4.11 Online interventions

Various terms are used interchangeably and inconsistently to refer to any treatment that takes place online, without face-to-face contact with a service provider. Such technology-based interventions include: computer-based interventions, online or internet-based interventions, phone applications, and smart or mobile phone interventions. An online drug treatment intervention has been defined as an internet-based programme that offers a specially developed, structured drug treatment intervention. It is thus different from more general websites providing information and education on substances (EMCDDA 2009). However, online interventions do not just deal with drug treatment. In a broader sense, online interventions have been defined as 'a professional offer in selective prevention that is delivered via internet, includes interactive elements and provides individual feedback to young PWUD. These online services can be fully automated and self-guided or include contact with a professional' (Steffens and Sarrazin 2015, 6). Online interventions can be unguided stand-alone interventions or *blended*, where they are an additional component to the usual treatment (Boumparis et al., 2017, 1522). The former is easily accessible and has the ability to reach an almost infinite amount of PWUS at the same time. *Blended* interventions, on the other hand, are usually supported by mental health or

addiction care professionals and are therefore more limited in their capacity. They are generally more used for abstinence-oriented forms of treatment. For the purposes of this chapter, we'll use online interventions to refer to any of the above-mentioned interventions.

Online interventions can be used to overcome obstacles to accessing treatment, thus reaching groups of users that are otherwise hard to reach. Access to more conventional interventions can be limited for a number reasons, including lack of access due to geographic distance, but also because of stigma, lack of trust, lack of anonymity, lack of service availability, financial barriers, or the requirement of abstinence as a treatment objective (Boumparis et al., 2017). Online interventions can be a solution to these obstacles. They are generally cost-effective and can be accessed at any moment, requiring only internet access (Steffens and Sarrazin 2015). A 2015 guideline lists the key recommendations for developing online interventions for people who use (illicit) substances (Steffens and Sarrazin 2015). It is mostly directed at young people and the use of NPS but is applicable more broadly and can be a handy resource for those interested in developing similar interventions.

There is a strong evidence-base for the effectiveness of online treatment interventions for a variety of mental health issues like anxiety, depression and other conditions (Steffens and Sarrazin 2015). The effectiveness of online treatment interventions has furthermore been established for people who use alcohol and nicotine problematically. There is particularly strong evidence for online self-help interventions, based on cognitive behavioural therapy (CBT), that aim to control and/or reduce alcohol use (Boumparis et al., 2017; Schaub et al., 2016; Steffens & Sarrazin, 2015). Some studies have been published on its effects for cannabis use as well. Most studies defined intervention effectiveness in terms of reduced drug use or treatment retention, but they have not included other parameters (Steffens and Sarrazin 2015).

There is little solid evidence about the effectiveness of online treatment interventions for PWUS. A recent meta-analysis on randomised clinical trials – comparing online interventions with control conditions – for people who use illicit substances (opioids, cocaine, amphetamines) showed a small but significant effect. When looking at all substances pooled, the review found that online interventions had some measure of success in reducing substance use. However, the only category of substances that did not show any significant effect were stimulants (Boumparis et al. 2017).

Some interventions aimed at PWUS are currently available and do seem to have positive results, although few have been evaluated thoroughly. A 2015 clinical study that assessed an online behavioural treatment (called Therapeutic Education System) showed that this intervention had significantly better outcomes (improving treatment retention and increasing chances of abstinence) for people whose primary substance of use was a stimulant, compared to other substances such as alcohol, cannabis, and opioids (Cochran et al. 2015). However, this might not be due to its online nature, but rather because the intervention combines two of the currently most effective evidence-based treatments for substances dependence: community reinforcement and contingency management (Campbell et al. 2014).

By now, several online interventions have been piloted for people who use cocaine and amphetamine-type stimulants (Schaub, Sullivan, Haug, & Stark, 2012; Schaub, Sullivan, & Stark, 2011; Tait et al., 2014, 2015). All these interventions are based on CBT. Another online treatment intervention supports clients with cocaine use problems who are already in methadone treatment (Carroll et al. 2014). Other interventions include a Japanese web-based relapse prevention programme named "e-SMARPP" based on an existing offline prevention programme based on CBT and motivational enhancement (Takano et al. 2016).

As mentioned at the beginning of this chapter online interventions are broader than offering (blended) drug treatment online. Harm reduction practices may consist of providing an online platform where PWUD can ask questions about drug use or to provide references to care or social services upon request. Thus far, no scientific articles could be located that focus specifically on online harm reduction (for PWUS). In chapter 5.2 we describe a Spanish programme working with an online intervention for chemsex users.

4.12 Therapeutic interventions

Although many therapeutic interventions are used predominantly in treatment settings, where the aim is to achieve abstinence, they can also be powerful tools in a harm reduction environment. These interventions can assist people in dealing with mental health issues and other problems associated with stimulant drug use, they can support people in developing self-regulation strategies, and people may benefit from therapeutic interventions in a drug treatment setting. Given the limited scope of this review, we will only discuss interventions aimed at addressing (acute) mental health issues, and issues more directly related to the use of stimulants (such as dealing with craving and managing use).

Comorbidity[2] is relatively common among PWUS and there are strong associations between substance use and mental health disorders, such as attention-deficit/hyperactivity disorder (ADHD), anxiety, depressive disorders, PTSD and eating disorders. Chapter 3.4 addresses the relation between mental health issues and substance use in more detail. PWUS can also experience acute mental health[3] problems as a direct result of their stimulant use.

The use of stimulants may occasion or exacerbate various mental health problems, such as anxiety, eating problems, depression, paranoia, sleep disruption and psychotic episodes. For more severe symptoms, the WHO indicates crisis interventions by mental health professionals. These interventions start by doing a risk assessment and evaluating the need for further psychiatric treatment (WHO, 2011). Staff working with PWUS in a harm reduction setting can apply several simple techniques to provide assistance to PWUS suffering from paranoid thoughts, anxiety or hallucinations. Useful tips are: be calm and reassuring; take the person to a quiet, calming place and try to turn their attention to something else; validate people's experience while avoiding acknowledging that their hallucinations are real (if

you are certain they aren't); help people to recognise the ways in which paranoia and anxiety may be associated with their drug use (Pinkham and Stone 2015). In some cases, people who use stimulants may experience acute psychotic episodes and can become aggressive, for instance in case of Excited Delirium Syndrome (EDS). This relatively rare medical condition, characterised by agitation, aggression, acute distress and sudden death, requires immediate intervention from medical professionals, often needing sedation (Takeuchi, Ahern, and Henderson 2011). It is important not to risk your own safety as a service provider if a situation appears to be dangerous.

Several evidence-based interventions in drug treatment can also be applied in harm reduction circumstances. Supported withdrawal is a strategy that can be applied by non-mental health professionals to help people who use ATS and want to (temporarily) stop using. In the case of methamphetamine, for instance, people are likely to experience withdrawal symptoms such as periods of prolonged sleep, increased appetite, irritability and anxiety. Others may experience more severe symptoms like clinical depression, mood swings, inability to experience pleasure, aches and pains, sleep disturbance, poor concentration and memory (Jenner and Lee 2008). Some supportive strategies are: telling the person what to expect during withdrawal, including probable duration and common symptoms, providing written materials as the person may have memory and concentration difficulties during withdrawal, assisting in evaluating what helped and what did not in previous withdrawals, and assisting in identifying key social supports (Jenner and Lee 2008). In addition, people can also enhance their self-control by focusing on pleasant and distracting activities, keeping close to supportive people, and maintaining a healthy diet and routine (Pinkham and Stone 2015). It is also possible to explore the need of referral to mental health interventions for continued follow up.

Interventions such as cognitive behavioural therapy (CBT), contingency management (CM), motivational interviewing (MI), family therapy, and brief interventions (BI), are regarded as key interventions in the treatment and recovery process for cocaine and methamphetamine use. They can help people identify drug-related problems and commit to change, increase treatment adherence, reduce drug-related

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2   Comorbidity is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder. In this case, when mental health illnesses and problematic substance use occur together.

3   An acute mental illness is characterised by significant and stressful symptoms requiring immediate intervention. It may be a first experience of mental illness, a repeat episode or the worsening of symptoms of a continuing mental health problem.

harms, and help create a support network (for instance, by including the family) (EMCDDA 2016). The EMCDDA best practice portal especially recommends BI and psychosocial interventions as harm reduction strategies for stimulants (EMCDDA 2018a).

CBT, CM and BI are typically used in outpatient settings. Their main aim is helping people achieve or maintain abstinence and to prevent relapse (Bisch et al. 2011; WHO 2011; Jean-Paul Grund et al. 2010). In Australia, a structured brief counselling model developed specifically for people who use amphetamine regularly sshowed, besides increased abstinence, short-term improvements on depression and improved risk management in tobacco smoking, polydrug use, risky injecting behaviour, criminal activity, psychiatric distress and depression (Baker et al. 2005) . An English study, however, found brief interventions to have no significant effect on abstinence in young, regular users of MDMA and (crack) cocaine when compared to a similar group which received written health risk information materials only (Marsden et al. 2006).

Community Reinforcement Approach (CRA) is a behavioural intervention that aims to show that a life without can be more rewarding than a life with substance use. CRA has also been applied in the treatment of people who use stimulants. There is strong evidence that a combination of CRA with incentives (such as vouchers exchangeable for retail items, or other care support) can help people to stop using cocaine, although long term maintenance may still be challenging (Roozen et al. 2004; Higgins, Sigmon, and Wong 2003; Secades-Villa et al. 2008). CRA also helped people who use both cocaine and opioids to engage significantly more in non-drug related activities. The planning and reinforcement of specific non-drug-related social, vocational, and recreational activities are likely to be crucial components of this approach (Schottenfeld et al. 2000). Lastly, the Matrix model, a treatment model specifically designed for people who use stimulants, which combines different therapeutic interventions, has been proven effective in the treatment for cocaine (Rawson et al. 1995, 2004) as well as methamphetamine use (Magidson et al. 2017).

Case studies

5 Case studies

In this chapter seven cases present more in-depth practical examples of some of the harm reduction interventions covered in the literature review. The selected cases represent a diverse range of: types of harm reduction interventions, types of stimulants, social and cultural contexts, gender aspects, types of drug policy in place, level of integration in health-care system, linkages with other (harm reduction) services, available resources, and geographical regions.

In alphabetical order the following seven cases will be presented:
- Atitude, a housing first intervention for freebase cocaine users in Brazil;
- Chem-Safe, an online intervention for MSM who use crystal meth and NPS among other drugs in chemsex settings in Spain (and other Spanish speaking countries);
- Contemplation groups promoting self-regulation and mindfulness among *Tik* (i.e. crystal meth) users in South Africa;
- COUNTERfit distribution of safer smoking kits for freebase cocaine and meth users in Canada;
- El Achique drop-in centre for marginalised *pasta base* users in Uruguay
- Karisma's outreach work for *Shabu* (i.e. crystal meth) users in Indonesia.
- Princehof, Ripperdastraat and Schurmannstraat, three drug consumption rooms for freebase cocaine (and heroin) users in the Netherlands.

For the purpose of this study we studied relevant (working) documents and spoke to various professionals and service users involved in the interventions. As previously mentioned, repondents signed a consent form, data has been stored safely, and quotes have been anonymised in the report in line with the most recent Data Protection Guidelines. Whenever a service user is quoted this is referenced as SU, and professionals are referenced as P.

All seven cases will be presented according to the same structure, providing insight into their social context, the origins of the intervention, in practice details on how they operate including staff and finances as far as this information was available, practical successes and challenges, future goals, and some lessons learned in conclusion.

5.1 Atitude
An approach to housing first in Brazil

'In the streets I had no safety. I was in a risky area, without housing and without respect. Now I have another life. I'm living here, I can visit my family, and I am seeing my children! My life has changed a lot.' — SU10

'Our main objective is that people develop their autonomy, that they can integrate into society, and continue with their life with better life quality.' — P6

Atitude is a governmental harm reduction programme from the state of Pernambuco, Brazil. Founded in 2011, the programme is part of a State policy to reduce highly violent and lethal crimes. Atitude assists people who use crack cocaine and are in violent and vulnerable situations, as well as their families. The programme works to increase people's life quality, promote social protection, reduce criminality, and prevent incarceration. In 2017, the programme assisted 154,626 people in 4 different municipalities: Recife, Caruaru, Jaboatão dos Guararapes, and Cabo de Santo Agostinho. The programme works with a levelled-care approach, offering four different services: outreach work (Atitude nas Ruas), drop-in centre and night shelter (Centro de Acolhimento e Apoio), intensive (day and night) shelter (Centro de Acolhimento Intensivo), and independent social housing (Aluguel Social). A separate intensive shelter exists specifically for females, welcoming especially mothers (to be) and female transgenders. Social housing provides social rent for users who are ready to have a more autonomous life and further integrate into society. For both PWUD, the government and the NGOs involved, Atitude is a great success among people who use crack in the state of Pernambuco. Service users particularly appreciate their relationship with professionals, the low-threshold approach and the possibility of having a safe space. Atitude helps them to get more stable and organised, and to develop control and autonomy in their lives.

Image 1: Recife, Caruaru, Jaboatão dos Guararapes, and Cabo de Santo Agostinho, Brazil

Brazil

Brazil is the fifth largest country by area and the sixth most populous in the world. Situated on the east coast of South America, it has a population of over 208 million inhabitants. The country is very multicultural and ethnically diverse, due to the strong immigration from various places in the world. Its official language is Brazilian Portuguese. From 2004 to 2014, poverty levels have decreased from

25% of the population to 8.5%. Extreme poverty[4] declined from 12 to 4% over the same period (Góes and Karpowicz 2017). Despite being classified as an upper-middle-income country, Brazil is still a highly unequal society.

Brazil occupies the fourth place among the most violent when compared to other Latin American countries. Violence is greatest among youngsters and black citizens. Homicide rates rise above 25 per 100 thousand inhabitants in Brazil, and 70% of the victims are black citizens. Among youngsters (between 12 and 21 years old) the homicide rate rises to 81 per 100 thousand inhabitants and, proportionally, black youngsters die two and half times more than white youngsters (Waiselfisz 2012). Drug trafficking and conflicts with the police are thought to account for a large part of the violence, mainly in the big cities (Rodrigues 2006).

Brazil has 26 provinces. The social housing and shelter programme studied in this chapter are running in four municipalities in the Pernambuco province, northeast of Brazil.

Substance use in Brazil
Brazil has a long history of stimulant use, with powder cocaine being in the market at least since the 1970's. Back then cocaine was mostly used by the middle/high income population. The first public scare related to this drug, however, started in the 80's, when injection use became popular and reached the outskirts population. Cocaine was the preferred drug for injection for virtually all the user populations at the time (Caiaffa and Bastos 1998), and injection use drastically increased the levels of HIV/Aids transmission due to the sharing of syringes and other materials (Júnior et al. 2009).

Injection use decreased, but a new *drug epidemic* arose with the introduction of crack cocaine into the market in the 90s. Crack cocaine spread particularly in socially excluded locations and populations. By the end of the century, it was dominant among homeless youth and adults. Some former PWID also switched to this drug. A few big cities in Brazil face the emergence of the *cracklands*[5]: large open

areas where people who use crack gather to buy, sell, use drugs and many times live. Most cities in the country do not have a *crackland* scene but are not less affected by crack cocaine. Due to prejudice and violence, people who use crack tend to hide into less visible spaces and smaller groups. This too is the case for people who use crack being assisted by Atitude. Crack use usually happens in more hidden spaces, due to prejudice and repression form the community and the police.

'Our users suffer violence from various sources: from the police, the community, the drug dealers.' — P3

To avoid violence and judgement, people tend to use crack in abandoned places, mangroves, public toilets, and spaces with less circulation of people. The media reinforces the image of the crack user as marginal, thieves, and vagabonds, demonising the substance and its users.

The street scene includes crack use and lately also the return to glue use. Due to the financial crisis and increase of poverty, some people have switched to glue sniffing as it is much cheaper than crack. People smoke crack mostly in home-made pipes made of plastic tubes; some smoke in soda or beer cans. Besides crack, the most used drugs in the street scene are glue, *loló*[6] and alcohol.

A study in four Brazilian state capitals in in- and outpatient public services, found that crack cocaine was the second most used drug by the population seeking treatment, just after alcohol. While 78% searched treatment for alcohol, 51% did because of crack use (Faller et al. 2014). In many outpatient drug treatment services, people wo use crack are the majority (Horta et al. 2011).

A national study found that approximately 40% of crack users in Brazil are homeless or roofless[7],

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4   Households whose income is less than $3.10 a day for poverty/ less than $1.90 for extreme poverty (US dollars).
5   Crackland (*cracolândia* in Portuguese) is a combination of crack + land, or land of crack. It originated as a popular denom-

ination for a region in the center of the city of São Paulo where there has been an intense drug traffic, drug use and prostitution, all highly focused on crack cocaine. The term is currently used to denominate an (open) place where crack (and other drugs) are used and sold.
6   Loló is the popular name of a home-based substance prepared with chloroform and ether. It is cheap and easy to prepare. Loló is used as an inhalant; put on a small piece of fabric and inhaled through the nose or mouth. It is also used directly, inhaling a canister or bottle through the mouth or nostrils.
7   Being homeless means not having a permanent place, even though one may have a roof over one's head. It may be staying on a

but less than 5% are in shelters (FIOCRUZ 2013). Regional studies found even worse situations. In Rio de Janeiro, for instance, 76% of people using crack were homeless or roofless for at least a year, and 25% were homeless for six years or more (Redes da Maré 2015). Violence is a daily challenge for roofless and homeless drug using populations. Besides, more than half of the female users in Brazil reported having been pregnant once or more since they started using crack (FIOCRUZ 2013). This population has very few or no specific services to take care of their needs, even less so from a harm reduction perspective.

Local research has shown that rather than becoming vulnerable because of drug use, most homeless and roofless crack users were already in a vulnerable situation which aggravated with their crack use (Rui, Fiore, and Tófoli 2016). Education, employment, and family relationships, are often areas of concern for individuals who use drugs and seek for treatment (Faller et al. 2014). Lack of documentation and a criminal record also hinder users' chances for improving life quality through study and employment (Redes da Maré 2015).

This context suggests that problematic crack use in Brazil is a social problem in need of structural solutions. Besides drug treatment and related care, people need programmes that promote safety and stability, also for those users who are not willing or not able to become abstinent.

Drug policy and harm reduction
In Latin America, Brazil was the first country to develop harm reduction strategies for crack cocaine users, such as outreach work and safer smoking kits. In the early 1990s the country had very repressive policies towards drug use inherited from its Military Dictatorship period (1964-1985) (Carvalho 2006). The HIV/Aids epidemic among PWID stimulated the development of harm reduction. During the 1990s, the country developed a harm reduction approach towards cocaine injection, with scarce resources and low community support. The first Brazilian harm reduction programmes, mostly providing for needle exchange and outreach work, were run by

non-governmental organisations (NGOs), supported by international donors and local government.

Brazil became a leading country adopting public health strategies (Bueno 2007). It is considered an example on harm reduction policies implementation, among developing countries (Mesquita 2006). In 2003, the Brazilian Health Ministry reformed its prevention and treatment policy regarding alcohol and other drugs, officially stating national political support for harm reduction strategies for the first time (Ministério da Saúde 2003). Financial incentives were given to public hospitals, Centres for Psychosocial Assistance on Alcohol and other Drugs (CAPSAD), mobile units and primary health care to work with harm reduction. These incentives were crucial to enhance sustainability. Rather than being carried out by NGOs and outsourced workers only, harm reduction started being carried out by civil servants as well. In 2006, another drug policy reform established that drug use is not a reason for arrest, even though one can be penalised with optional treatment, counselling and/or community work (Brazil 2006). However, since the law does not define clear quantities allowed for possession, it is at police discretion to decide whether a given case concerns drug use or trade.

In 2010, the 'Integrated Plan to Cope with Crack and Other Drugs' was launched by the national government, focusing on the integration of prevention, care and law enforcement (Brazil 2010). The governmental plan, however, mainly offered financial incentives to abstinence-oriented services. Despite the meagre financial support, several harm reduction programmes and strategies led both by government and NGOs have been popping up around the country. In 2018, in the context of a political crisis with corruption scandals and the contested impeachment of the former president, the National Secretary of Drug Policies approved a new resolution affirming abstinence as the main objective of Brazil's drug policies. The National Secretary of Drug Policies also position itself against legalisation and avoid the term *harm reduction* (CONAD 2018). It still uncertain how this may impact harm reduction services around the country including the Atitude programme.

Origins of Atitude
The activities which would later form Atitude started in 2007. At that time, the cities of Recife,

friends' couch or in emergency/temporary accommodation. Being roofless means having no alternative but to sleep rough on the streets and parks.

Olinda and Jaboatão dos Guararapes had youth centres which were assisting in cases of violence. Youth centres provided food, workshops, financial aid and help with income generation. Drug use cases were referred to CAPSAD's. When the centres set up outreach teams, they started accessing a drug using street-based population who had life-threats due to the drug scene and trafficking.

'We needed to do something, because these people were dying. Not necessarily because of the use, but because of the problematic use coupled with the trafficking scene. [...] We say that however small a debt may be, there comes a time where it is no longer possible to pay. The dealer doesn't want the money anymore, but the person's life'. — P1

In 2010, with support from the State and the National government, three Reference Centres for Drug users (CRAUDE) were created, as one-year pilot projects. These were walk in centres with a night shelter and an outreach team.

'In the CRAUDE we received people in the house from 8AM to 8PM. We started hearing from users who were involved in drug trafficking that when it was time to close the service they didn't want to leave. They could not go away. They were afraid of dying. And we found it difficult to close the service. This population was not being assisted anywhere else, it was a population that – until then – was at the margin.' — P2

At the end of the pilot period of CRAUDE, in 2011, the staff migrated to houses located in strategic areas with high rates of drug-related violence and, more specifically, drug related homicides. These areas were the metropolitan area around the capital, Recife, and the rural area of the *Agreste* region of Pernambuco. And so Atitude was born as it is organised today. To the outreach work and drop-in services, the programme added an intensive shelter (day and night) and independent social housing. Atitude programme currently works in four municipalities in the State of Pernambuco: Recife, Caruaru, Jaboatão dos Guararapes, and Cabo de Santo Agostinho.

Atitude is part of a State policy called *Life Pact*, aiming to reduce de incidence of lethal violent crimes in Pernambuco. More than 40% of the programme participants already suffered from an attempted murder. These are related to drug dealer debts, gang fights, and general street vulnerability. Many of them have life threats and those still living on the streets suffer from constant police violence and brutality. Besides, 30% of the service users has attempted suicide in the past (Luis Ratton and West 2016).

'We must make this reflection about harm reduction and how it is different here from, say, developed countries, where the focus is very much on health. [...] Our users are not dying because of the harms caused by the drug. Our users are dying because of violence, and they die daily. Of course, we need to pay attention to health, but we also need to look at violence, and how the war on drugs has been killing people.' — P4

Atitude is fully funded by the State government. Different from most drug programmes – which are linked to Health Secretaries – Atitude is linked to the Secretary of Social Development In 2015 the programme suffered budget cuts due to the financial crisis in the country. The annual budget of around €4,2 million was reduced to €2,8 million. Some services had to be suspended while others were downsized. The programme could not pay workers on time and had to dismiss more than 100 people. Slowly the programme recovered, but up to 2018, not all activities are back into place yet.

In practice

Atitude works with a levelled-care approach, offering four different services: outreach work, drop-in centre and night shelter, intensive (day and night) shelter, and independent social housing. Besides the mixed shelters, an intensive shelter specifically for women exists in Recife, welcoming especially mothers (to be) and female transgenders. The different services are integrated, but users do not necessarily need to pass through the outreach or drop-in services to get access to the intensive shelter or social housing. The level of care a service user will receive depends on his/her needs and capabilities. When a PWUD is new to the programme, an individual support plan is set up. This plan will accompany PWUD across different services and can be modified according to the person's needs and wishes. Given this case study's focus on housing, we will describe Atitude's shelters and social housing more elaborately than the other services on offer.

The outreach service focuses on PWUD living or staying on the streets. Outreach workers go to areas with a higher level of lethal violent drug related crimes. They offer water, condoms, information on how to reduce the harms of drugs, and referrals to places where people can get further help. The outreach team also sensitises local services to work with a harm reduction approach. Besides reaching out to users, they can also assist users' families, and help to rebuild or strengthen family relations, focusing on the possible support the family can offer the service user. Many users get to know and access Atitude via outreach.

The four drop-in centres and night shelters work 24/7 and each assist around 30 users during day time, and 15 overnight. During the day users can eat breakfast, two warm meals and a snack. They can also sleep, shower, wash their clothes, watch TV, play a game, make use of health assistance, and join one of the many groups and workshops offered by the programme. The ones staying at the shelter get a bed in shared rooms, lockers to store their personal belongings, and an extra evening snack. At the night shelter, people facing more vulnerability in terms of violent threats or health get priority.

The four intensive shelters also work 24/7 and again each assist around 30 people. Service users can stay for up to 6 months. At the intensive shelters users have a routine, which in general includes: joint meals, housekeeping tasks, outings, and participation in groups and workshops. The housekeeping schedule is organised at the start of each week. Teams are made responsible for different parts of the house (rooms, garden, bathrooms, kitchen). Besides for practical reasons, these responsibilities help service users to develop housekeeping skills, working towards the possibility of a more autonomous and healthier living.

'Since many of them were homeless for quite some time, they end up losing some experience in housekeeping. And here, with the weekly tasks, teams have a daily responsibility for maintaining one part of the house. Every week, they can choose what they want to do. This stimulates their autonomy and improves their household skills for when they leave the programme.' — P9

A cleaning service cleans the areas of the house which are not dedicated to service users. The intensive shelters have a few rules: no fighting, no stealing, no sex (as rooms are shared), no consumption of illicit drugs or alcohol inside the house, and smoking cigarettes in smoking-areas only. Most rooms are shared with four to eight people. Usually, shelters have a house pet. Many users see the shelter as a welcoming home:

'I like the girls who live there, the house, the talks we have, the counselling I get. Everything I would like to have in my own house, but I don't, I have inside here.' — SU16

While staying at the shelter, service users can leave the house, but outings must be agreed upon with their case managers. Staff members evaluate with service users if they can go out and they give advice on avoiding risk areas and behaviour. After an outing, users need to come back to the shelter on the agreed date and time. Outings can for example be scheduled to visit family, have a date, work, study, go to a care service, drug treatment, or to use drugs. Many participants said to use cannabis to fight crack cocaine cravings.

'We ask for outings to go to CAPSAD, the health care centre, work, visit family, children [...] And there is also the 'harm reduction outing'. That is, for many of us, using cannabis. Then we get half an hour, we go, use and come back.' — SU13

When going out to use drugs, service users mostly use in the streets. When they have money, some prefer to rent a room in a cheap hostel. Atitude staff understands that street drug use exposes users to risks. However, drug consumption rooms are not legal in Brazil, and the programme risks being closed down if allowing drug use on its premises.

One of the unique services Atitude has on offer is an intensive shelter for women and female transgenders who use drugs, focusing on those who are threatened by violence and are mothers (to be). Kids up to 2 years can live with their mothers in the house. During their residence at the shelter the team works on strengthening self-care, mother-child bond, family relations and autonomy.

'My son was living with an aunt of mine and now that I'm here I can finally have him with me. This is extremely supportive, it helps me so much!' — SU14
A lawyer works part-time in the house to help those women who want to regain the custody over their kids, mostly taken away due to negligence and/or crack use. The lawyer also tries to prevent loss of child custody and can help with any criminal charges women may have.

In the drop-in centres and the night- and intensive shelters service users can attend a variety of thematic groups. Participation is voluntary, but the groups are usually full. Groups can discuss: harm reduction; community life and conviviality); family (held together with family members); culture and reflection (debating music, poetry and texts); working with self-esteem and self-care; and networking skills (housing access and accessing care services beyond Atitude). The Programme also offers educational workshops. They range from learning how to read and write to acquiring skills which can be used in the formal and informal labour market. Sometimes, users who are already in social housing and have a specific skill (capoeira, art craft, hairdressing) are invited and paid to give workshops. Besides, the staff offers external activities such as going to a movie, theatre, visiting a touristic place, or enjoying public sports facilities. These leisure activities are meant as an incentive to service users to occupy other spaces of the city and to enjoy activities beyond drug use. Another weekly group is the assembly enabling meaningful participation:

'Every Wednesday there is an hour assembly where service users discuss issues important to them. They run the assembly, present their proposals and lead the agenda. [...] It is a co-management space. They propose changes, suggest workshops, talk about schedule, relationship with staff, and propose conviviality rules.' — P3

According to both staff and users, most of the issues brought by service users are implemented.

In independent social housing, Atitude offers housing with rent up to 600 reais (around €130) a month for 6 months, and this is renewable for 6 months more. Houses can be for the user alone, with their family or together with three to four users. Besidesthe rent (usually all-inclusive), the programme offers a basic kit: a bed, a fridge, a stove, and a monthly food parcel box. Service users choose the house and the neighbourhood they want to live in, based on safety and family or friendship relations. Places where they have been threatened or places representing too much risk of going back to problematic crack use are usually discarded. Houses need to be in a region where there is primary health care and other fundamental services, basic sanitation, and when kids will be living there, nearby schools.

During social housing the support focuses on strengthening self-organisation and autonomy:

'We stimulate income generation and work placement, we ask them to look for a house for when the programme is no longer there, and to get organised so they can pay for the rent. [...] We try to bring the responsibility back to them, to build autonomy.' — P7

Generally, people who get into social housing are already working informally, such as selling snacks or drinks at traffic lights, taking care of cars or cleaning. The team helps users to further engage into the labour market by helping them organise their CVs, applying for job vacancies, and reintegrate into the community.

'We are already saving money and we will rent our own house. We sell water at the traffic light. If each day we save 20 reais, at the end of the month we have the money for the rent.' — SU7

In social housing staff and service users have weekly meetings to discuss their personal organisation and plans. Issues coming up can range from the type of furniture to buy and how to make their own food, to how to deal with loneliness and the new daily responsibilities.

Staff and finances
Atitude is fully financed by the state government and runs through a public-private partnership. Resources are transferred from the government, through the Atitude programme, to four Civil Society Organisations (CSO), and these manage the services and resources. 50% of the budget is destined to personnel, and the rest is for rent, cars, fuel, food, maintenance and other things. The three CSOs currently managing Atitude programmes are Cercap

(in Caruru), IEDS (in Jaboatão dos Guararapes and Cabo de Santo Agostinho), and CPD (in Recife).

Each one of the four social housing services employs a full-time psychologist or a social worker and a full-time driver.

Each intensive shelter employs: a full time coordinator and a supervisor, a full time administrative person, two full time psychologists and two social workers for 30h/week, four social educators (two for day and two for night shifts, working 12/36) , two care takers for night shifts, four vigilantes (two for day and two for night shifts, working 12/36) , three cooks (one full time and two working 12/36), two cleaners (working 12/36), and three drivers (one full time and two 12/36).

The drop-in and night shelters have similar staff from Intensive shelters, minus the drivers and having four social educators in addition.

Each city has two outreach teams, and each team is formed by one full time psychologist or social worker, one full time social educator and one full time driver.

In 2017, the total budget for Atitude was around €3.870.163. Each intensive shelter assisted, on average, 187 individuals a year. The average cost per person a year in these services was around €2.491. For the same year, social rent services assisted, on average, 16 people a year each. The average costs per person assisted/year was €2.821. For the walk in/night shelter, these numbers were 609 persons assisted and a cost of €756 per person/year. For outreach, costs go down to € 59 per person assisted (more than once – 1147 PWUSs) a year and € 7,40 per person approached without further referrals (9149 PWUSs). Costs per capita were calculated discounting for people who were assisted by more than one service in Atitude.

Teaming up

A good amount of networking happens among the different services of Atitude programme. When one service has no vacancy and there is an urgent situation, the first step is to refer to another Atitude service in a different city. There is also a constant flow of service users between the different levels of the programme. This happens either because service users can get more independent levels of care, or because they cannot cope with the required autonomy for a certain level and need a

Table 1: Number of staff involved

Service	Recife	Jaboatão dos Guararapes	Cabo de Santo Agostinho	Caruaru
Shelter	27	25	25	25
Social Housing	2	2	2	2
Walk-in/night shelter	28	29	28	29
Outreach	6	6	6	6
Total	248			

Table 2: Financial resources Atitude in 2018

Service	Recife	Jaboatão dos Guararapes	Cabo de Santo Agostinho	Caruaru
Intensive shelter	€ 472,604.52	€ 440,194.91	€ 438,239.84	€ 436,855.03
Social Rent	€ 55,042.37	€ 55,220.14	€ 55,042.37	€ 55,274.63
Walk-in/night shelter	€ 440,730.45	€ 470,522.10	€ 438,339.21	€ 454,768.54
Outreach	€ 70,679.28	€ 70,679.28	€ 70,679.28	€ 70,679.28
Social security and employment charges	€ 67,212.10	€ 67,673.48	€ 65,592.67	€ 65,729.65
Total per service	€ 1,106,268.73	€ 1,104,289.91	€ 1,067,893.37	€ 1,083,307.12
Total	€ 4,361,759.14			

*1€= R$ 4.3915 (Brazilian Reais)

lower-threshold service. It can also be that users leave the programme and come back weeks, months or years later. Many participants we interviewed had passed by different services of Atitude.

Besides this internal network, Atitude also works on connecting users to other services in the city and region. Before Atitude is implemented in a city, the municipality is required to have minimum of services available: A Psychosocial Centre for Mental Health assistance, a Reference Centre for Social Work (CRAS), a Specialised Reference Centre for Social Work (CREAS), and Primary Health Care.

The partnership with CRAS and CREAS is helpful for users to access social benefits, arrange personal documents (such as ID, birth certificate, voter ID card), and get access to professionalising courses. Usually, service users do not have documents, so they need to organise that at the start of their trajectory.

For professionalising courses Atitude also has partnerships with Federal Institutes in a few cities (such as Caruaru). Some of the courses available are: professional laundry, recreation in parties and events, mechanics, fashion design, bakery, cooking, or sales. Staff tries to adequate courses available through public services with the interest of service users. Users benefiting from professionalised courses are usually those in the intensive shelter or social housing, as they are better organised and working on their financial independence. For those who cannot or have difficulties with writing and reading, the Paulo Freire programme offers workshops inside the Atitude services.

Furthermore, staff refers to primary health care, hospitals, CAPSAD, emergency units, orthopaedics, pneumology, gastroenterology, HIV, syphilis and hepatitis testing and counselling, and dentists.

'We get a lot of requests for the general practitioner and the dentist. When people stop using problematically, tooth pain comes very strongly. [...] They didn't keep good personal hygiene and - as the dentists say - prolonged use of crack can wear tooth enamel. They also often have stomach aches. When they start reorganising their life, sleep in the service, eat, decrease crack use, then they start feeling the pain.' — P5

The major cooperative challenges lie with the judiciary and the police. Particularly, in the case of drug using mothers, judges tend to take the custody from mothers, unless they are completely abstinent from drugs:

'To take the children from a mother [...] should be the last resource. We try to advocate for this. [...] The judges, to most of them harm reduction does not exist. They think a mother cannot, in any way, be a drug user. This is really unrealistic.' — P8

Partnerships with the police are also very challenging. Service users assisted by the outreach programme have frequently reported beatings and surprise raids by the police. Police workers have a list of social and health community services they need to visit in their areas, as part of their work with the community, and the Atitude drop-ins and the shelters have been included in this list. A few police officers will enter services and sit down to talk and play games with users. Other officers, however, will enter with machine guns and refuse to talk to service users. And some will not visit the services at all. Several police officers question the work being done at Atitude, since there is no enforced abstinence. According to the Atitude staff, police officers still need to gain a proper understanding of what harm reduction is and change their behaviour towards PWUD and the programme.

Successes and challenges
According to both service users and staff, the programme has many successes. In a previous evaluation of the program, service users declared that Atitude helped them to increase self-care, organisation and wellbeing, strengthen family relations, decrease crack use and anxiety, increase sociability and protection against violence, and brought a feeling of being welcomed and respected (Luis Ratton and West 2016). In our interviews, all these successes were mentioned by staff and service users and, in addition, users referred that Atitude helped them to increase control over crack use and have or increase income generation.

Although Atitude does not focus on the drug use per se, the safety it promotes led many to decrease their crack use or to use it in a more controlled way. According to participants, having a place to stay helps to decrease the compulsive use of crack

(OSF 2017). From the 93% which were identified as frequent crack users before the start of the programme, 36% stopped crack use and 64% decreased consumption (Luis Ratton and West 2016). A more controlled use of crack was also mentioned by our study's participants:

'Atitude helped me to get more organised [...] I lost my job, lost almost all my teeth because of crack use. I almost got killed, I starved, robbed, and lied a lot to obtain drugs. Nowadays I still use drugs, but I do it in a completely different way. First, I organise myself. The money I get first goes to all the needs I have: food, clothing, perfume, work materials. And I only use twice a month. [...] I use knowing that the day after I do not have to work or wake up early. Because I know I'll still be under influence and tired, and I cannot assist my clients that way.' — SU4

According to staff, housing plays a big role in the opportunities people get:

'We see that the drug gets to play a different role in their lives. It no longer has the main role. That's when we see that this is a social issue, it is not a drug issue [...] If you have other choices, other opportunities, your life does not revolve around drugs. When you take care of your own house, experience the pleasure of cooking your own lunch and have your son over for lunch, it all changes.' — P7

Image 3: Sharing pictures during staff visit at social housing

Having a house also brought service users a sense of calm, through having a safe space and being able to take responsibilities:

'Everything started moving on as it should after I got into social housing. I have my safe port, my house. I arrive, I shower, I turn the TV on... I have my space, my tranquillity. I have responsibilities and I am happy. Social housing showed me that I can maintain a house.' — SU6

Social housing service users, in general, develop a good relationship with the neighbourhood and feel proud for being able to take care of themselves and, in some cases, their children. For some, however, the relative isolation of living in a house instead of in a shelter or the streets, and the increased responsibilities coming along with that can be challenging. In one case a user was feeling too lonely and staff helped with increasing work shifts and engaging in social activities besides work. Sometimes users have difficulties taking care of a house and maintaining themselves financially. A few ask to return to shelters to feel safer. After having referred social housing users back to shelters many times, Atitude staff has now changed their perspective. From previous experiences, staff said, they learnt that it is better to help users to cope with the difficulties while staying in social housing, so to enhance their autonomy.

It has also happened, however, that people in social housing relapse into uncontrolled crack use and end up selling the furniture and/or abandoning the programme. These situations can be very challenging. When service users sell their furniture, they are dismissed from the programme. Sometimes people come back after a week or two asking to return to the shelter or another service. Staff decides case-by-case whether that is possible and if the service user has to return the sold objects or not. As all objects are owned by the government, the programme is held accountable for any losses, but at the same time they need to deal with the reality of their service users.

Also, intensive shelter beneficiaries mentioned that the programme helped them to decrease their use, increase self-care and learn different ways for generating income. Occupying themselves with arts and crafts, selling drinks and snacks at the traffic light, washing cars or cleaning houses gave people

another perspective on what they can do with their time. The workshops offered by Atitude taught people how to produce things and how to sell them as well, for instance how to use *selling techniques* and calculate a fair selling price:

'Nowadays I can survive from my words. I've learned how to talk to people. I get some popcorn bags and I go to the traffic lights to sell it. I say "good morning" to people, I have my selling pitch. It is a way to maintain my drug use without doing anything wrong, without robbing.' — SU3

One challenge, still, is entering the formal market. By April 2018, the unemployment rate in Brazil was 13%. Besides, formal jobs account for around a third of the market. By the end of 2017, only 36% of the economically active population had formal jobs, while 25% were autonomous workers and 12% worked informally (IBGE 2018). Many PWUS do not have enough formal education or experience to compete for vacancies in the formal market. In a previous research, 97% of users in intensive shelters declared their health increased after they partook the programme (Luis Ratton and West 2016).

Another benefit that participants mentioned, in all programme levels, was that Atitude helped them to rebuilding family relations. Especially for female users, strengthening the bond with their children was mentioned as an important achievement. Both for users and for staff, this reproaching process was usually related to developing self-care first:

'We start the process of self-care by incentivising them to start taking care of themselves. Not only in terms of hygiene, but to look at themselves, think about what they want, what their purpose inside the house is, why did they join the programme. They start to think about it, we can see the changes [...] Once they start caring about themselves, the care for their children also increases.' — P9

Many women also used to be in abusive relationships, and their participation in the programme helped them to build and engage in healthier relations. Staff discusses these issues both in groups and individually.

Image 4: Female intensive shelter

Despite the successes, some women have difficulty bonding with their children, even when they express the desire of having the kids close to them. Sometimes their kids were in shelters for a long time, and the relationship must be rebuilt. It may be as well that they do not spend the weekend with the children when they can, or do not have the patience to take care of the children when they are around. According to Atitude staff, many women had the experience of previously having someone helping to take care of their children and tend to look for that in the service. In these cases, staff tries to work with their autonomy. When a mother must clean the bathroom and take care of the baby at the same time, for instance, staff helps them develop strategies to do both things at the same time without depending on someone else. It can be as simple as doing the activity when the kid is asleep.

A final important challenge the programme faces is the lack of vacancies. Even when services are operating in their full capacity, still there are people who would need the services but cannot enter. The team tries to work with priorities, giving preference to more severe cases of vulnerability, health and violence. Finding priorities among a population who is already extremely vulnerable, is perceived as a hard task. An added challenge is that since the financial crisis in 2015 some services were closed, such as the male intensive shelter, and staff was dismissed. This directly impacted staff's work, and many feel the demand is much higher than what they can offer. Staff tries to assist more people than the capacity and tries to find alternative services or allow users to stay for a longer period than the usual norm.

Moving forward

Atitude staff and beneficiaries hope for the programme's growth. Both staff and users would like Atitude to expand to assist people under age. There are many under aged crack users in very vulnerable situations who need help, but they currently do not have a place to go. Plans to assist under 18 from a harm reduction perspective are challenging. According to the Judiciary underage people cannot decide for themselves what is best for them, and so, abstinence is the best approach. Atitude is still lobbying for it.

The programme also has plans to improve its network for employment for service users. They are searching for partnerships with companies who could hire people and perhaps have tax deduction in return. This type of partnership has to be developed by the government in the Drug policy Secretariat, and the programme hopes to have this function working soon. Another important plan is to develop a better partnership with law enforcement so that police workers can support the program's activities in the streets and in the services. It is a paradox to have the state supporting harm reduction but perpetrating violence against PWUD at the same time.

One of the main aims of Atitude for the future is to assure the programme can keep its activities and increase its budget and vacancies.

'I would really like the programme to grow. Because we see that the programme helps them. And we see that there are so many other people who could be part of the programme and could be helped but are not because there are no vacancies.' — P9

Besides more vacancies for service users, staff would also like to have more human resources available to be able to better support users. Service users as well, would like the programme to offer more houses, more vacancies in shelters and in the drop-in centre so to benefit more people. They all know a lot of other people using crack who could benefit from Atitude, and in general, they all evaluate Atitude as the best service available.

Challenges here are resistance of some municipalities as well as politics.

'We still have to face resistance from some municipalities. In one case the municipality says that Atitude has brought crack users to the city. Even though our data shows that most users we assist in the area are from there.' — P2

The current shift in the national policy direction is also worrying management and staff. The programme was established by a decree, but in case a radical policy shift takes place, they fear for the repeal of the decree or a drastic decrease of budget. Everyone, however, is fighting to keep up the hope.

LESSONS LEARNED

1 Be welcoming and promote autonomy. Service users need to be respected in their limits and supported in their possibilities.

2 Having an integrated housing programme helps to keep in touch with service users and adapt to their life and drug use support needs as these develop along the way.

3 Believe in the people you assist and build services with their participation.

5.2 Chem-Safe
An online intervention for chemsex users in Spain

'[The Chem-Safe consultation] has evidently changed my life- I have stopped consuming stimulants regularly and above all my use of alcohol has dropped a lot. Sometimes I take stimulants, but I no longer have the need to fool around all the time. If I can have sex, I do. And if I can't, I don't and that's that. I'm much calmer now.' — SU2

In 2012, professionals working in the fields of drug use and sexual health first noticed the chemsex phenomenon among LGBT communities in Spain. As of 2016, scientific evidence has confirmed these observations. Similar to other big European cities, chemsex has been on the increase within specific groups of men who have sex with men (MSM) in large cities in Spain, particularly Madrid and Barcelona. Chemsex is the intentional combination of sex with the use of certain drugs, primarily in private settings among men who have sex with men (MSM) (Bourne, Reid, Hickson, Torres-Rueda, & Weatherburn, 2015; Giorgetti et al., 2017; McCall, Adams, Mason, & Willis, 2015; Stuart, 2016). It is a complex phenomenon, involving drug use, issues around infectious diseases, associations with psychosocial and psychiatric issues, sexual orientation, as well as the association with risky (sexual) practices. In response to the increase in chemsex in Spain, Energy Control – a programme under the Spanish NGO Asociación Bienestar y Desarrollo (ABD) – started an online project called Chem-Safe, in 2017. Its aim is to provide objective information and advice to people who use drugs in a sexual context, including some specific information for people living with HIV (who may be on antiretroviral treatment) (Asociación Bienestar y Desarrollo 2017). All information and advice is based on prevention and harm reduction principles. Additionally, the website aims to connect NGOs working in different fields. The website chem-safe.org was launched in January 2017, in collaboration with various organisations working in the fields of LGBT rights, PLHIV, and

Image 5: Spain

harm reduction. In April 2017, an on-line advice and support service was added. Later that year, a blog was also added to the website.

Spain
Spain is a large South-European country. Mainland Spain borders the Mediterranean Sea (and Morocco) to the south, the Atlantic Ocean and France to the North and Portugal to the West. Its territory includes the Balearic Islands in the Mediterranean and several islands including the Canary Islands off the coast of Africa. It is home to roughly 46 million

Image 6: Main illustration on website front page

inhabitants. Spain is a constitutional monarchy and a democracy, its constitution dating back to 1978. The country suffered under the dictatorship of general Franco until 1975, after which the country slowly transitioned back to democracy. Spain is a highly decentralised nation, consisting of 17 autonomous communities, and two autonomous cities. Each autonomous community has its own government, parliament, and resources. Importantly, health and education systems fall under the autonomous governments. Within the country, different nationalities,

such as Basque, Catalan, Galician, and Andalusian are recognised, and in addition to Spanish, other languages are officially recognised as well. The Spanish economy relies heavily on the tourism industry. Receiving a record number of 82 million tourists in 2017, it was the second most visited country in the world by tourists (La Moncloa 2018).

Spain was one of the European countries that was most heavily affected by the economic crisis that started in 2008. People continue to be affected by insecurity in the labour market and the long-term unemployment rates are among the highest compared to other countries in Europe or the OECD (OECD 2018a). Young people are especially affected, with unemployment rates ranging from a high of 57% in 2014 to almost 40% by the end of 2017 (OECD 2018b). Spain also counts among the most unequal countries in Europe (following only Serbia, Bulgaria, Lithuania and Romania), scoring

34,5 on the Gini index, which measures differences in income inequality. Since 2014, the country's GDP has grown, but with it, economic inequality has also increased. Spain is the second country in the EU where inequality has grown the most since the economic crisis, and where it has continued to increase despite recent years of economic growth (Oxfam Intermón 2017).

Substance use in Spain

In Spain, the prevalence of substance use has been relatively stable over the last few years, although prevalence of the most consumed substances – cannabis and cocaine, respectively – are above the European average. Substances are mainly consumed by people below 35 years (EMCDDA 2017d). However, the population with which this chapter is concerned – MSM who practice chemsex – has a different profile. In Spain, the practice of chemsex is more commonly referred to as a session. It is a relatively new phenomenon in the country, and for that reason, there is limited scientific literature. Sensationalist media attention, on the other hand, has not been lacking. Despite disproportionate media coverage, scientific studies and respondents in our study agree that the phenomenon is still relatively small and primarily concentrated in the country's largest cities: Madrid and Barcelona. In addition to their size, it is likely that their status as popular tourist destinations for LGBT tourists connects them more to the rest of Europe (Zaro et al. 2017). Most MSM that practice chemsex in Spain are single, highly educated males with an average age of

35. The large majority (almost 80%) uses geospatial apps – like Scruff and Grindr – to contact other men. Men also connect through websites, bars, and clubs (Zaro et al. 2017).

A recent survey among people who practice chemsex showed that the most commonly consumed substances among this group are poppers (85%), GHB (71%), Viagra (70%), alcohol (69%), cocaine (63%), ecstasy (61%), mephedrone (56%), methamphetamine (42%), and ketamine (40%) (Zaro et al. 2017). Of the stimulants, cocaine and mephedrone are most often snorted, although 10% of the respondents in this study also reported injecting mephedrone. Methamphetamine is mostly smoked (57%), but also snorted (19%) and injected (11%) (Zaro et al. 2017). Respondents agree that methamphetamine, better known as *Tina,* and mephedrone are the stimulants most used within the chemsex scene, with methamphetamine being more common in Barcelona, and mephedrone more common in Madrid. The informative pages on the Chem-Safe website that are most frequented by visitors are those on methamphetamine, mephedrone, GHB and ketamine, which further suggests that these are the most used substances.

According to a recent chemsex study, injecting stimulants, or *slamming*, is uncommon among men (Zaro et al. 2017). Most respondents in this case study agree with these findings. This is partly because injecting is still connected to marginalised heroin users of the 1970s, especially for older users. The younger people that practice chemsex see it as something more erotic and more connected to drugs and sex.

'The younger population that doesn't recognise injecting drugs as something marginal or 'junkie' began to eroticise it, seeing it as something associated with desire and sex. Therefore, this conception of marginality and exclusion associated with injecting got lost. To the point that today within the chemsex scene, it is sometimes conceived as something aesthetic, not as something linked to social exclusion.' — P5

Those that do *slam*, rarely share injection materials (12%). Snorting equipment however, is shared frequently (85%). Recent scientific studies have noticed various links between (mental) health issues on the one hand, and the use of *geo-local-isation* apps, participation in group sex activities, the (poly-substance) use of novel psychoactive substances such as mephedrone, on the other hand. Researchers notice a high prevalence of psychiatric disorders (most notably anxiety, depression and adjustment disorders), but also psychosis related to *slamming* mephedrone (Ocón 2017; Fernandez-Dávila, Folch, and Roca 2017; Fernández-Dávila 2016; Caudevilla-Galligo 2016; Ballesteros-López et al. 2017; Dolengevich-Segal et al. 2016).

Drug policy and harm reduction

Spain's National Drug Strategy focuses on both supply and demand reduction, which includes prevention, risk and harm reduction, treatment and social reintegration. Launched in early 2018, the National Strategy on Addictions (ENA) 2017 – 2024 builds on previous National Drug Strategies (e.g. the National Drug Strategy 2009 – 2016) and various Drug Action Plans. It aims to create a healthier and more informed society, by reducing both the demand for drugs as well as the prevalence of addictions. Its second main goal is to create a safer society, by means of supply reduction (Ministerio de Sanidad Servicios Sociales e Igualdad 2018).

At the national level, the Spanish Council for Drug Addiction and Other Addictions is responsible for the development and implementation of all drug and addiction related policies. The Government Delegation for the National Plan on Drugs is the national drug policy coordinator, and falls under the Ministry of Health, Social Services and Equality. It coordinates the institutions involved in delivering the drug strategy at central administrative, regional/autonomous community and local levels. Each autonomous community also has its own drug commissioner (EMCDDA 2017d). Drug consumption is not criminalised in Spain, although use in public is a serious offence, punishable by a fine. The overwhelming majority of drug law offenders are charged with possession-related offences, in 80% of the cases this is related to cannabis (EMCDDA 2017d).

Harm reduction is one of the ENA's principal objectives. Spain has a large public network of harm reduction service providers that offer e.g. 'overdose prevention activities, sterile needles and syringes, testing for drug-related infections, vaccination against hepatitis A and B and emergency care and assistance to injecting drug users' (EMCDDA 2017d). Opioid substitution treatment is also available

nationally, and the autonomous communities of Catalunya and Basque Country offer drug consumption rooms (EMCDDA 2017d).

Origins of Chem-Safe

Around 2012, professionals working in the fields of sexual health, harm reduction, addiction care, male prostitution, and LGBT communities started noticing that MSM were increasingly using substances in sexual contexts. During HIV and STI consultations, patients reported the use of (injected) drugs during sex and mentioned experiencing adverse effects of their drug use. These observations were solidified with the publication of several scientific articles in 2016 and 2017. Chemsex is considered a complex phenomenon, having links with risky (sexual) practices, and in turn, with the transmission of infectious diseases such as HIV and the hepatitis C virus (HCV). Coping with a recently diagnosed HIV-status can be difficult. According to several respondents, some men deal with this by diving into the chemsex scene; some immediately start *slamming* even if they hadn't used drugs previously. It is also associated with low treatment adherence among PLHIV, and MSM that participate in chemsex often face problems of self-esteem, difficulty to accept one's sexual orientation or internalised homophobia, loneliness and social isolation connected to being HIV positive (Asociación Bienestar y Desarrollo 2017). In addition, respondents also notice a lot of anxiety, depression, mood disorders, and, in some cases, psychotic episodes. These findings confirmed what had been noticed in other major European cities such as Berlin, London and Amsterdam, and increasingly by professionals in Spain as well. Public health institutions seemed to have little knowledge about or services for this emerging phenomenon, and this subgroup of MSM.

For these reasons, in 2016, Energy Control proposed to create a platform to inform this target group, as well as connect them to various friendly organisations (based in Barcelona, Madrid, Valencia and Basque Country) working in complementary areas such as LGBT rights, (sexual) health promotion, HIV treatment, gender and sexual diversity, social inclusion, and harm reduction. In consultation with eleven NGOs and other organisations, Energy Control coordinated the development of an informative website around chemsex. Its aim is to provide objective information on substances, drug interactions,

risks as well as harm reduction tips for this high-risk population. The website is targeted towards MSM that use drugs in a sexual setting and is based on a harm reduction and prevention approach but can be useful to anyone who uses drugs in a sexual context. A small section of the website is meant for professionals and includes several recent scientific articles and studies as well as links to other additional information.
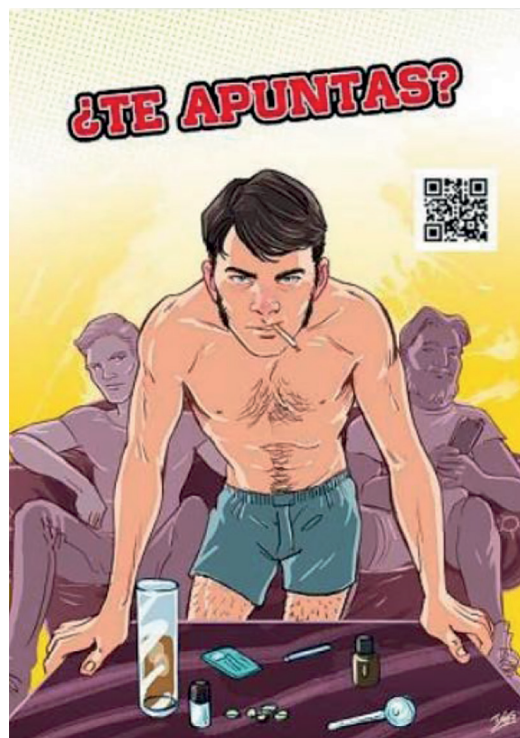
Image 7: Frontpage of distributed flyers

The website chem-safe.org was launched in January 2017. In April 2017, an on-line advice and support service was added, which can be reached by filling in a request form on the website. Dr. X, who is the project coordinator working (as a volunteer) on this project, responds to most questions by email. More complicated questions can be answered via videoconference.

The target population consists mostly of adult males. The majority is roughly 35 years and older, although one respondent did mention having contact with a

16-year-old boy that practiced chemsex as well. 50 years of age is often mentioned as the upper limit. According to respondents, the majority comes from the middle or upper class and has a stable working situation. At the same time, they also see that this stability is threatened by their involvement in chemsex, leading to economic, social and work-related deterioration. Respondents add that other important issues for this group are more psychological in nature, e.g. internalised homophobia, and *serophobia* (not accepting one's own homosexuality and HIV+-status, respectively), as well as depression, anxiety, and stress related to sexual orientation and HIV status. Chemsex users face complex issues, in part because issues around problematic drug use, sex and some of the above issues such as intimacy are strongly intertwined.

'With Tina I did things that maybe I didn't want to do, but that I was doing because at that moment I thought I wanted to. And then the next day you regret it. Oh well, that's typical for Tina. [...] Of course, I liked the sex, but I missed the emotional bond. [...] I used drugs to get rid of the blockages in my head, so I could experiment with new things. At the least I wanted to have an emotional connection with the people with whom I did it, so as not to feel bad afterwards.' — SU3

This group is seen as very difficult to reach for various reasons: because they don't consider their own practices to be risky, because chemsex takes place in private settings, but also because most harm reduction practices are often geared towards marginalised people who use heroin, and because men frequently encounter professionals that are unfamiliar with phenomenon.

In practice
Flyers, posters and postcards have been disseminated in various settings - NGOs, health professionals working in HIV units, specialised sexual health centres, mental health units, centres for drug addiction, and primary healthcare centres – to promote the Chem-Safe website. Flyers and postcards have also been handed out by peer educators during outreach activities in nightlife settings such as gay saunas, sex clubs and bars. However, respondents mention that many people working with potential chemsex users in nightlife settings are reluctant to distribute materials related to drugs because in

Spanish law, the owner of a club can be held responsible if drugs are taken in his venue.

Still, others collaborate actively and openly and see the added benefit of informing visitors of their clubs, bars, saunas et cetera, and some do distribute materials such as flyers and postcards, but do not want to be associated explicitly with the Chem-Safe website (Asociación Bienestar y Desarrollo 2017).

Additionally, banners have been placed on specific websites (such as a website for male sex work, telechapero.com) and in apps dedicated to gay contact and sex (such as Grindr and Scruff). The website is also actively promoted during trainings on chemsex, given by the Chem-Safe project coordinator to professionals working with the target group. Additionally, online classes were delivered to Spanish and Latin American universities in courses on public health and sexuality.

In July 2017, a blog was added to the website, called *se abra le sesión* (the session has opened). This is an explicit referral to chemsex, which is called a session in Spanish. The goal of the blog was to attract more visitors to the site. An interview with the famous Spanish-Mexican artist Alaska was especially effective in attracting more visitors.

Image 8: Main illustration of chem-safe blog

Of the 159 requests that were received in 2017, roughly 87% concerned requests from chemsex users for more information about drugs, sex, chemsex, and infectious diseases, of which 4% came from healthcare professionals. 11% were requests for information on or collaboration with NGOs,

research institutes or government institutions (Asociación Bienestar y Desarrollo 2017).

Of the service user (SU) requests, the majority can be quickly responded to by email. Several requests are longer and more complex, in which case service users are invited to have a consultation by telephone or videochat, or, if possible, to contact an organisation in their hometown. A few service users needed an additional intervention after having been consulted.

'These interventions have been useful to refer problematic chemsex users to specific organisations in the real world.' — P1

Different respondents have different ideas about the objectives of Chem-Safe. This is partly due to how closely they were involved from the beginning, and partly due to the background of their own organisation's goals and response to chemsex issues. The different organisations involved in the Chem-Safe project offer a range of different services to service users: psychological and social care, psychiatric and medical care, sexual health prevention, sexual therapy, harm reduction interventions, community interventions etc. This facilitated an effective exchange between experts from different perspectives and complementary work areas to collaborate.

Linking is an important objective of Chem-Safe for many respondents. Sometimes these links are established directly through the website, and sometimes more indirectly and/or informally through individual contacts. Professionals frequently mention that they collaborate with other institutions that work around the theme of chemsex, allowing them to more easily refer service users there, and have service users referred back to them. Since chemsex is considered a complex phenomenon, involving various levels of care and SU needs, ensuring access for service users to complementary services is considered very important.

'The most important thing is linking. Ensuring that clients do not stop going to the check-ups: to the psychologist, the psychiatrist, the doctor [...] I believe that in order to start treating chemsex users, we need both this linkage and a risk reduction programme. The traditional treatment programme doesn't work for chemsex users.' — P2

In some of the Chem-Safe partner projects, service users have the option to volunteer and contribute. As one professional puts it, this makes the project

'more bidirectional, more reciprocal. And in the end, this gives better results in the long run.' — P5

One respondent mentions that the objective varies per SU: while some want to completely stop using drugs, others may only want to quit those substances that generate the most problems for them, or they are simply looking to be informed about ways of reducing the risks. Respondents do agree that in general, the fundamental objective is the quality of life of the service users. Most service users found Chem-Safe because they were experiencing health issues related to their substance use, as explained by the following service user:

'I used to combine methamphetamine with viagra and alcohol. A couple of times I got a big scare: I became short of breath and had heart palpitations. I started looking for information and ended up finding ChemSafe. I had a phone consultation with Dr X. He basically told me about the interactions and their effects because that's what must preoccupied me. It did not have a direct impact on my consumption pattern. But over time, I did stop using stimulants. It made me realise what I was doing, and how self-destructive I was being. It was part of a personal process. It's not like, say, oh, thanks to that consultation, I'm going to stop using drugs now or I'm going to stop having sex with drugs. It is something more thoughtful.' — SU2

According to several respondents, the final goal is to improve the quality of life of service users.

'It was all pretty haywire. When you're using heavily, you do not sleep for a week, you eat like shit. [...] After I spoke with Dr. X, he gave me some advice, and in fact I decreased my drug use a lot. I am more peaceful now, more relaxed. [...] I feel better, not in such a foul mood all the time. I'm eating better, sleeping much more. I'm doing more things, being more productive. And I'm connecting more. As I told you, I would be very obsessive. Whether it was talking and talking and talking or being all obsessed about sex. Now I can spend time watching a bit of television and read the papers.' — SU1

One respondent, who works as a specialised nurse in the HIV unit of a hospital, purposely puts Chem-Safe posters in her consultation office, to ensure her patients that chemsex is a subject they can discuss openly. According to her, it's very important to ask patients directly if they're involved in chemsex. If they do, she sits down with them and they go through the Chem-Safe website together, to learn more about the substances and the risks.

In terms of harm reduction, both professionals and SU respondents mention that despite a lack of proper evaluation, anecdotally they do notice that Chem-Safe has helped service users change some habits, reduce and/or gain more control over their substance use, by becoming better informed about the risks of combining substances, routes of administration, and about the risks of STI and HIV transmission.

'We do see changes in people's behaviour. One client of mine who never used to care about his drug use and interaction with his ARVs, now asks us first. Recently he asked me: "this Christmas I'm going to practice chemsex. I'm taking this and this and this. Can you tell me if these interact with my ARVs?" I evaluate this positively: it has created a consciousness among our target population.' — P5

'The information [on Chem-Safe] is quite real. In the beginning, I was totally uninformed. I had no idea. I was worried, but I had that self-destructive tendency and in spite of reading these alarming sensational messages about methamphetamine, the only thing these did was to further encourage my capacity for self-destruction. [...] Having more truthful information, it helped me to really understand what I was doing and to stop doing it.' — SU2

Usage data of the website has only been gathered for the first year – from January 2017 to January 2018. The website receives an average of over 10,000 visits a week, the majority from big cities in Spain, although 12% of the visits came from Latin America. Its coordinator also holds two to three weekly videoconferences with service users, which is an indication of its usefulness. The website thus functions as a potential referral to more personalised consultations, which in turn can function to refer service users to appropriate care offline. Themes of consults included the interaction between ARVs, other pharmaceuticals and drugs; adverse effects; guidelines for substance use; HIV transmission risks; substance dependence; and overdose and toxicity (Asociación Bienestar y Desarrollo 2017).

Staff and finances

The creation and launch of the website was initially financed by a pharmaceutical laboratory (ViiV Healthcare). €8.752 was spent on creating the website, which costs included human resources; illustration and design of postcards, posters and flyers; printing costs; and the costs for five working days (Asociación Bienestar y Desarrollo 2017). Energy Control received a total of €14,000 from its sole donor for a period of two years. This money has covered most of the initial expenses, but leaves nothing for the coordination of the website, or the creation of additional content.

The project coordinator estimates that around €25,000 would be needed on an annual basis to support such a project. Currently, the project coordinator runs this project in his spare time, which is a source of frustration and impairs progress of the project

All respondents – both professionals and service users – mention that financial support is lacking. None of the organisations get paid specifically do work with chemsex, although in some organisations the financing is *transversal* or *integrated*, which means that working on chemsex related issues is part of their regular work.

Table 3: Staff involved

Function / job title	How many	Salary / time spent
Project coordinator	1	Part-time, voluntary
HIV and STI nurses, sexual health consultants, LGBT support staff, harm reduction and (drug) prevention experts, etc.	>11	Part-time, voluntary

Image 9: Chem-Safe partner organisations [excluding Energy-Control]

'There really is no funding. There are very few means. People are putting in a lot of effort and a lot of professionalism but nevertheless there is no economic support from the public institutions.' — P5

According to the project coordinator no funding has been made available, despite having gotten positive recognition from relevant ministries. On the one hand, respondents understand that funding is complicated, since Spain is still experiencing an economic crisis, and other public funding – such as for Alzheimer's research – has also decreased. On the other hand, respondents fear that prejudices play a role, since politicians and policy makers believe that chemsex only affects gay men, it is not a public health issue. Another problem mentioned by several respondents is that in Spain, you first need to prove a problem exists and that you have a working solution before it's taken into consideration for funding.

'So far, everything has depended on the good will of the people involved.' — P2

'I do this because I like the work and because it's necessary, but sometimes I also get tired. I would like to have more time, but I'm pessimistic. Support ought to come from public health institutions. However, in Spain, unless there's data, they don't want to hear about it.' — P1

Teaming up

The working group to create Chem-Safe consisted of 12 organisations, including Energy Control. The project is open to all LGBT organisations.

'The idea was that we [Energy Control] are experts in drugs, you are experts in LGBT and HIV and sexuality issues; let's work together.' — P1

Chem-Safe continues to collaborate with various organisations in several cities in Spain, for instance to promote awareness of the project, but also to refer clients (both ways). These include three HIV/ civil rights associations, two LGBT associations, the HIV unit in a hospital, and several primary care centres. Many of these organisations offer assistance to problematic chemsex users that Chem-Safe - as an online project – cannot offer. Furthermore, many of the Chem-Safe partners also collaborate with other (public) health institutions. Respondents mention that although they feel that in an ideal world, there would be integrated treatment for chemsex users, they are already happy if, for example, a nurse working with HIV positive patients in a hospital, knows that they can refer patients to non-judgmental/ LGBT-friendly drug treatment centres. In some cases, clients will even be physically accompanied to addiction treatment centres.

'It's important to work in a network. In the end, the problem is so serious that we need the support of all institutions (NGOs as much as public institutions). Then, working with partners is very important to achieve objectives. And we know from experience that providing comprehensive attention gives good results.' — P5

Through the Chem-Safe network, many services for PWUD are available, including but not limited to: needle and syringes, safer smoking kits, opioid substitution treatment, drug consumption rooms, drop-in centres, HIV, Hepatitis and TB testing and counselling, (social) housing and other structural interventions, behavioural treatment and other psychosocial interventions. Some respondents suggest that offering more trainings would be useful, since very few professionals (including medical professionals working with PWUD and drug experts) know anything about chemsex. Direct (medical) attention that is geared towards this target group is also seen as lacking, e.g. when service users have acute problems such as psychotic episodes, health problems or very elevated substance use.

'They feel very lonely, there is no support. The web is informative but needs more attention.' — P2

Successes and challenges

Chem-Safe can be considered a success in that is a pioneer intervention, combining education, prevention, and harm reduction strategies, targeted at a novel risk group. Also, the Chem-Safe managed to create an intervention that addresses the myriad issues associated with chemsex, despite little knowledge being available on effective ways of doing so.

'What I like about Chem-Safe a lot is that it presents drug use as something multidimensional. That is to say: it is not only the drug, but it is also you and your context that affect consumption and that together can cause abuse or addiction.' — SU3

In the absence of integrated or specialised services for chemsex users, the close collaboration between different organisations and the establishment of new collaborations, networks and initiatives are all considered successes. 'Instead of creating new resources for specific, concrete and changing demands, the synergy between existing lines of work optimises resources, enriches professionals and

contributes to integration' (Asociación Bienestar y Desarrollo 2017). The fact that some former chemsex users are now contributing to an organisation involved in the Chem-Safe project is also mentioned as a success by one respondent.

The involved collaborating parties are all committed, which is also testified to by the fact that various parties (web design, illustration, graphic design, supervision, writing etc.) have contributed much more time and effort to the project than was budgeted and paid for. Bringing aboard different types of organisations provides access to this otherwise difficult to reach group of chemsex users. This is further aided by the Chem-Safe website's non-judgmental tone of voice and provision of objective information.

'What's positive is how information is presented: at no time is it judgmental or does it try to be scary. It is clean information and above all truthful, backed by a medical team.' — P6

The Chem-Safe website allows many people to access reliable information, anonymously and confidentially. This is considered especially important when people feel embarrassment or are stigmatised because of their sexual orientation, HIV status, or drug use. Website visitors can access associated organisations directly by clicking banners on the site itself, if they feel the need to ask more direct questions or if they think they have a problem. Although no statistical information is available on how it has impacted service users, both professionals and service users mention that it has helped service users become more conscious of their consumption patterns and that it has actively contributed to less harmful, more controlled or reduced drug use.

'Man, yeah, for example the interactions with HIV drugs, what I can and cannot take, to what extent, if I can mix it or not. I already had some information for each specific drug, but it was general information, and [Chem-Safe] puts it in a sexual context. For example, when you take GHB, watch out with Tina and separate your doses of G at least one hour. But also, adverse effects, duration, potency, interactions. It has helped me understand when and how I can take something and at what time. Before I used to be like: "This sounds good, I'll take it."' — SU3

Additionally, the mere fact that the website is actively consulted is an indication of its success, as are the various more in-depth consultation requests, including videoconferences as an intervention tool. One respondent, although still critical of the project, acknowledges that it is the biggest online resource in Spanish, and they reach an audience in Latin America as well.

According to the respondents, most challenges revolve around the lack of funding, and as a result, not having paid staff and having insufficient time. The website's blog is a case in point: it's considered a useful means to attract more people to the website, however, only four blog posts were published in 2017, and thus far, only one in 2018. This is the result of not having any paid staff, and only one staff member working on this project voluntarily, who in addition to his regular job, is responsible for the provision of online consultations and trainings to professionals, as well as feeding blog content.

Both financial and political support are considered very sparse by all respondents. With the exception of Catalunya, where chemsex is considered a public health issue, in the rest of Spain no funding is available. Political support is equally absent across the board. This lack of interest is explained by various respondents as having to do with the phenomenon being primarily associated with MSM.

'I find it worrisome. It reminds me a lot of when HIV came up. At first it only affected the homosexuals, and nobody cared about anything. And only when it reached heterosexuals did institutions begin to worry about the issue. What I think may be happening is that institutions may not be alarmed until chemsex affects the heterosexual population.' — SU3

Chem-Safe has faced several other challenges. The website has received criticism on some of the available content, e.g. on expressions that were used or aspects that were lacking. Other criticism was considered less fair by respondents, for example for being sponsored by the pharmaceutical industry. Also, some actors from the Spanish LGBT/HIV activist community criticised Energy Control for becoming involved in 'a field that is not theirs' (Asociación Bienestar y Desarrollo 2017).

'Some part of the LGBT community is too strict in dogmas, like "chemsex only happens in gay people, so we need a gay doctor for this." There is some auto-stigma going on as well.' — P1

Also, among some members of the LGBT community, drug use is still stigmatised. While sex no longer seems to be a taboo, drugs still are, which makes it difficult for organisations to work on prevention and harm reduction in gay saunas, clubs and sex clubs.

'Everyone thinks its right to have sex clubs where you can do fisting and pissing, but no one can talk about drugs. Drugs have a taboo, not only in the gay community but also in gay saunas, gay sex clubs.' — P1

Reaching the right population continues to be a challenge, for various reasons. As mentioned earlier in this report, in instances of public substance use, the owner of an establishment can be held accountable as well, which means some proprietors are reluctant to advise or inform their customers, making the distribution of flyers and leaflets problematic. Also, a website might not reach the whole target population. As one respondent explains, men who practice chemsex are much more likely to use a mobile app instead of visiting a website. A suggestion for improvement would be to ally more closely with oft-used apps for gay contact such as Scruff and Grindr, not by adding banners but e.g. by adding a menu option on chemsex. Finally, some respondents consider it a major challenge to reach men who are unaware they might be at risk and feel in control and might not want information about substance use and associated risks. Reaching that group is a major challenge, to which respondents don't immediately have a clear answer, but the fact that many official institutions such as clinics are uninformed about chemsex does not help. One suggestion that was mentioned was to hold more informal informational group discussions about the subject.

Moving forward

Both the content section of the website as well as the blog need to be regularly updated. Maintaining an active and continuous presence on social media can help connect better to chemsex users as well, as well as help to quickly spot new trends and substance use patterns. Since chemsex is a relatively new phenomenon that is still evolving, this is important in

order to provide a tailored and adequate response. More statistical, quantitative research would also help in this area, as well as improve understanding of the specific impact of Chem-Safe.

Another area for improvement is the scale of the dissemination. Many respondents mention that more dissemination of balanced information, both by distributing informational materials as well as by providing interactive meetings/talks, is needed to create more awareness of this issue, e.g. in the streets, health centres, nightlife locations, and in general among the LGBT community. Many respondents, both professionals and service users, state that a successful harm reduction-oriented approach for chemsex would require close integration of many different services, but in the absence of such an approach, closer collaboration between different entities, including state health services (such as hospitals, GP and health clinics) is crucial. Finally, despite a lack of financial and human resources, the coordinating entity Energy Control is committed to maintaining the Chem-Safe project, which is a potential safeguard for its sustainability.

LESSONS LEARNED

1 An important first step in setting up a project like Chem-Safe is to start with a field study to find out exactly what is happening: who is involved, what substances are being used and how, do they *slam* their drugs, what health problems do they experience and what potential solutions and resources are already available (within the public health sector) being also crucial.

2 Establish a network of different (types of) like-minded, cooperative organisations, including public health services, that offer complementary services for the target population. Since problematic chemsex is a multifaceted issue that requires addressing many different elements at the same time, being able to refer clients to friendly services is important.

3 Present the information on drugs, sex, and associated risks in a matter-of-factly and non-judgmental way, in the language that the target group itself uses. Combine the provision of objective health information with the option of direct contact with an open-minded professional who can consult and refer service users.

5.3 Contemplation groups
An approach to self-regulation in South Africa

'Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom.' — Viktor Frankl in Man's search for meaning.[8]

'The only outcome we should be seeking, is that people are, most of the time, empowered and free to make informed conscious decisions about the type, frequency, method and purpose of their drug use, whether they choose to use drugs, or not.' — Shaun Shelly, original founder of the contemplation groups.

Contemplation groups are group sessions for substance users with a specific harm reduction focus. They were developed in 2012 and have since then been offered in slightly differing formats at four different locations in two cities (Cape Town and Durban) in South Africa. The groups consist of eight to twelve sessions, addressing self-awareness, the setting of small goals and future perspectives. Experience has demonstrated that it works particularly well among stimulant users. It is an inexpensive and low-threshold harm reduction service, which can also be implemented in a more abstinent oriented environment.

The intervention is all about strengthening individuals in their ability to choose healthier and happier lives. This is done through support in self-reflection, understanding oneself now and in the (near) future, knowing your triggers, and defining how you want your relationship with substances to be. It aims to make people more conscious about their lives and to own their drug use.

'When you decide to use, you decide to use. And list the benefits of it. Maybe there are no benefits. If so, either you change your drug, or change your way, or lower your tolerance for a while, or find something else to do.' — P1

Image 10: Cape Town & Durban, South-Africa

As described in the Contemplation Group Facilitators Manual (Shelly, Mac Donnell, and Sedick 2017):
- 'The primary purpose of the group is to encourage the participant to:
- Evaluate their current situation.
- Assist them in deciding which areas of their life need improvement.

8   Viktor Frankl (1905 — 1997) was a Jewish Austrian neurologist and psychologist. In his book *Man's search for meaning* he wrote about is experiences in a concentration camp and the importance of finding meaning in all forms of existence.

- Let them decide what changes need to take place for that improvement to occur.
- Evaluate and make informed decisions regarding their drug use (and TB and HIV treatment)'.

South Africa

South Africa is the most southern country on the African continent. According to the United Nations database, the country had a population of 56.7 million people in 2017 (UN data 2017). South Africa is a heterogeneous and socio-economically unequal society. According to the World Bank's Gini index, measuring inequality, South Africa is the most unequal country in the world.

The constitution recognises 11 official languages, the most common three being isiZulu (23%), isiXhosa (16%) and Afrikaans (13.5%). While English is only the first language of 10% of the population, it is a common second language and widely used in media, business and government (Alexander 2018). In 2015, 55.5% of the population (30.4 million people) lived below the poverty line. Although this is a decrease since the 66.6% in 2005, the poverty numbers have been rising in recent years, from 53.2% in 2011 (STATS SA 2017).

South Africa has 9 provinces. The contemplation groups studied in this chapter are/were running in three different organisations, primarily based in Cape Town, in the Western Cape province. However, one of the three organisations –TB HIV Care– also runs the contemplation groups in Durban, in Kwazulu Natal.

Substances used in South Africa

The two most used drugs in South Africa are alcohol and *Dagga* (i.e. Cannabis). South Africa does not have regular nationally representative surveys on drug use. However, the South African Community Epidemiology Network of Drug Use (SACENDU) regularly collects data from people being treated at government-funded as well as private rehabilitation centres throughout the country. Keeping in mind that treatment data is not representative for the total PWUD population, as many never access treatment facilities and the threshold to do so might be higher for some user groups than others, this chapter largely draws from SACENDU data.

According to SACENDU, in the second half of 2016, *Dagga* was the primary or secondary problematic drug for 35 to 51% of patients. In almost all monitored regions *Dagga* is the primary drug of choice among people under the age of 20. In this same period, alcohol was reportedly the primary drug of choice for 18 to 47% of patients in treatment (SACENDU, 2017).

Another widely used drug in South Africa is the downer *Mandrax* (i.e. Methaqualone) (Rigoni 2016). This drug is mostly used by men and has been in popular use since the 1970s all throughout the country. Another downer, which has been on the increase since the beginning of this century, is heroin. The heroin is chased off foil, but over the years there has also been an increase in people who inject. In South Africa, heroin is also referred to as *Nyaope*. The quality of heroin varies. Furthermore, *Whoonga/ Cocktail* (i.e. low-grade heroin mixed with *Dagga* and other ingredients) is widely smoked in Pretoria and the Gauteng region (Rigoni, 2016). *Whoonga* is primarily used by black Africans.

In the Western Cape the main problem drug is *tik* (i.e. methamphetamine). In this province its production, distribution and use have been on the increase, since it first came to attention in 1998 (Rigoni, 2016). Similarly, Versfeld (2013) describes how *Tik* arrived in a local Cape Town community with a bang, in 2002. While not even registered as a problem substance in 2003, *Tik* was the main substance for half the people in rehabilitation centres in the Western Cape in 2007 (Versfeld 2013). This percentage had decreased to 29% in 2016 (SACENDU, 2017). Besides, in almost all other provinces – apart from in the Eastern Cape, where *Tik* use is also rather common – *Tik* as primary substance of choice is low, ranging from 1 to 6%. Contrary to *Mandrax, Tik* is also widely used by women (Versfeld 2013). Traditionally *Tik* is smoked through *Lollies* (i.e. glass pipes), but just like with heroin there has also been an increase in injection use of *Tik* in recent years.

Since the end of apartheid in the mid-nineties, accessibility to all drugs has increased immensely, particularly among black and coloured communities (Rigoni 2016). While *Mandrax, Tik* and heroin are at present widely spread throughout the poorer communities, cocaine remains to be a drug for the wealthier population, and treatment admissions with

cocaine as primary problem drug remain low across the country, ranging from 1 to 5% (SACENDU, 2017). Nevertheless, TB HIV Care's low-threshold service in Durban reports that about half of their service users use *Rock* (i.e. freebase-cocaine) besides heroin. They smoke the *Rock* in glass pipes, different from the *Lollies* used to smoke *Tik*.

The organisations included in the field research for this case study, all provide services to marginalised PWUD, who often struggle with basic needs such as access to primary health care, employment and housing. From the perspective of these organizations, the two stimulants that play a significant role in the lives of marginalised and/or problematic PWUD are *Tik* and *Rock*. *Tik* is predominantly used in Cape Town, and *Rock* in Durban. A social worker in Cape Town reports that probably around 95% of the service users uses *Tik*, but for several freebase cocaine is a secondary substance, after heroin. When asked, professionals and service users alike confirmed the high prevalence of poly-substance use, many combining their *Tik* or *Rock* with heroin. However, this could also be due to the fact that all who reported this were related to TB HIV Care in Cape Town and Durban, where a large proportion of service users makes use of their Opiate Substitution Therapy (OST) services. Moreover, some more elite sex workers who make use of the services of TB HIV Care snort cocaine HCl.

Although *Cat* (i.e. methcathinone) is available throughout the country and was reported in most treatment facilities in late 2016 (SACENDU, 2017), it did not come up as a significant drug in the lives of service users in this field study.

Drug policy and harm reduction

In general, drug policies and services in South Africa have been predominantly focused on abstinence and supply reduction. However, over the years a gradual shift towards the embrace of harm reduction, both in the field and in policy documents, has taken place.

In the National Drug Master Plan (NDMP) 2013-2017 the Central Drug Authority (CDA) already acknowledged the need for a shift from dealing with the drug problem through supply reduction to 'a strategy based on the need to prevent the risk of substance abuse/dependence' (CDA, 2013: 5). However,

while the plan addressed the need for community-based solutions and prevention, the definition and inclusion of harm reduction remained vague. Up to this date most harm reduction activities in South-Africa remain to be financed by international donors, thus strongly affecting the sustainability of these programmes. At present, local and national policies seem to become more supportive towards harm reduction initiatives, albeit hesitantly. Through empirical evidence of its effectiveness, the support for OST and NSP is slowly on the increase in some sectors. For instance, the capital Pretoria in Gauteng province started funding a Community Oriented Substance Use Programme since 2016, which works with a harm reduction approach and includes OST and NSP services since 2017. In the meantime, however, some parties remain strongly opposed. While still in the draft stage, and with some fear that it will not come through in the end, it also seems like the NDMP 2018-2022 will incorporate some big changes towards the acceptance of harm reduction.

Origins of the contemplation groups

The contemplation groups were developed at Hope House, a Christian organisation offering counselling, addiction support and training to people in Cape Town. For several years, Hope House offered a low-threshold outpatient-based centre in the Cape Flats, the poor suburbs of Cape Town. Although the organisation did and continues to favour an abstinence-based response to drugs, this location switched to a harm reduction approach in 2012. The transition included the introduction of contemplation groups.

'Harm reduction was a necessity, rather than something we thought we would try. It was just becoming more and more evident that abstinence was not going to work.' — P2

The Hope House service users generally smoked *Tik* and *Mandrax*. Later, heroin became more popular, as did intravenous use. The service users lived in a broken community, generally homeless, from a very low socio-economic background, in an environment with high crime rates and gangs. Many people were just not ready for abstinence, and the service had to drop their punitive approach towards drug use to have any impact on the service user's lives. They introduced the contemplation groups:

'With the abstinence-based programme [...] they (i.e. the service users) had very little choice. They were pushed into abstinence and there was very stigmatising language. Whereas with the groups they started to have a choice: "do I want to change, what do I want to change, if I change what are the parameters, what are the negatives?" And once they had choice, their decision to engage with the therapist became much greater. Because there was no right or wrong. It was their choice and we would support them in the best way we thought we could.' — P2

Although this outpatient centre of Hope House is no longer running, a similar transition happened at the TB Hospital DP Marais in Cape Town. Up to 2014, the hospital maintained a zero-tolerance policy towards substance use among its clients, and all communication was abstinence based. However, a significant amount of their patients uses substances, continues to do so during and/or after their treatment, and treatment adherence among these patients is low. Of the 31% of patients who had a treatment default, 90% also had alcohol and drug use indicated in their files (Versfeld and Mac Donnell 2016). Hence, the hospital ran a study and pilot project, seeking to change their response to drug use, to enhance treatment adherence and address barriers to treatment completion, from 2014 to 2016. While neither the involved researcher, nor the hospital staff was harm reduction minded at the beginning of the trajectory, the support for such an approach grew as the pilot progressed, among the researcher, the hospital's Occupational Therapy (OT) staff, and some of the medical staff.

During the pilot project the hospital made several changes, including improving intakes with patients to get better insight into substance use relevant for treatment in a simple manner, handholds for hospital staff to respond to behaviour rather than to the fact that a patient uses substances, staff sensitization training, and the introduction of contemplation groups (Versfeld and Mac Donnell 2016). In these group sessions patients are stimulated to reflect on the drug use and TB treatment in a non-judgmental and supportive manner. These groups are still running in 2018 within the context of the hospital's OT, albeit adapted to their situation.

'It is still eight sessions, but I have adapted it a lot to make it more interactive, because of the different levels of function of our different patients. We made it very activity based, with more games, so it is more interesting, and to get everybody involved.' — P4

Lastly, the TB HIV Care Association has started offering contemplation groups at their drop-in centres in Durban and Cape Town, over the course of 2017 in relation to their OST pilot projects. TB HIV Care is an organisation that works to prevent, find and treat TB and HIV in communities in three provinces in South Africa. While the groups were traditionally developed for *Tik* users, they also work well for heroin users who have access to methadone. Besides, reportedly the majority of heroin users in the programmes also use *Tik* and/or *Rock*. Again, the groups are set up with the intention of strengthening substance users to make their own decisions on how to improve their health and lives in general. Also, adaptations have been made in order to make it more fitting into the local demands, such as adding more sessions on Harm Reduction in Cape Town and making it more practical and interactive (and less textual) in Durban.

All contemplation groups described here are part of a broader service. The methodology of the groups, as well as their broader context is discussed in the following section.

In practice
The strong focus on individual needs and responsiveness to the needs and capacity of the group make that the specifics of each group can differ. Nevertheless, some basic essentials can be defined. According to its founder these are:
· Stimulating mindfulness, and thereby learning to embrace triggers and be present and in the moment.
· Respectful to individual goals and improvements, so people can explore their own choices. The group is a safe space, where everyone is equal.
· Acknowledge small improvements. People do not have to identify as (former) drug user or say how long they have been clean. Small and short-term goals, even if only on this same day, can be discussed.

'And if all goes well, practice has taught us that the group will turn into a (second) family. The concept is

a little like motivational interviewing, where very few practitioners really know all the technical details of the method. Although useful to know, these details aren't essential to put the practice in place. It is an underlying philosophy, a base to fall back on as a practitioner.' — P1

Thus, the contemplation groups provide room for reflection, they focus on the individual and offer support in creating a sense of identity and future other than one as problematic drug user. It helps PWUD to be aware of their feelings and dilemmas and realise that they are so much more than a drug user.

Originally the group was set up to consist of eight sessions. However, at Hope House they were offered open ended. They are developed in such a way that the groups continue to have value when doing a second or third cycle. For the groups in the TB hospital some adjustments were made to focus on TB treatment adherence. Aside from some content changes the groups remained to consist of eight different sessions. At TB HIV Care, where the groups were still under development in 2018, they had expanded the contemplation group to twelve sessions, adding four new themes to the package:

1. Why am I here, where am I going?
   - To help person understand why they came to the group, give a sense of future and encourage to engage for own personal reasons.
2. Mindfulness
   - Give basic understanding of mindfulness, explain the advantages of being more mindful, teach basic mindfulness technique, and go through 'wheel of awareness'.
3. Journaling
   - Explain why journaling is useful, teach how best to use a journal, either start or add to journal.
4. Risks and rewards
   - Help to identify the risks of using and put a plan into place to reduce the risks and identify the pros and cons for staying the same, changing or quitting drug use.
5. Introduction to functional analysis
   - Stimulate thoughts about circumstances of use, discuss link between thoughts, feelings and use, explain triggers and automatic actions in response.
6. Problem solving
   - Learn how to better solve problems and develop a sense of responsibility.
7. Pay-off matrix
   - Help to evaluate drug use, to make decisions around changing drug use, and to set clear goals, also encourage self-efficacy and needs identification.
8. Looking forward
   - Help to develop short term goals, help to prioritise these goals and help to identify purpose in life.
9. Behaviours that help
   - Identify behaviours that are not so helpful and understand why these behaviours have developed and when they occur, also identify more helpful behaviours.
10. Taking inventory
    - Help assess own helpful and less helpful behaviours and learn how they are related to each other.
11. Who am I – what do I stand for?
    - Help to understand what is important to someone, help understand own values and where their boundaries are.
12. You have the power
    - Show that people have skills and link these to empowerment to make positive life changes.

The sessions can be attended separately and are voluntary, but a certificate can be earned for attending the whole programme. For each session materials exist to give the facilitator handholds in the group. Facilitators can work with separate worksheets for each session, in which both the purpose and methodology are described. Also, goal sheets have been developed to hand out to participants for them to keep track of the goals they set and their achievements in this. On this sheet harm reduction goals are prompted, stressing that abstinence really isn't the only possible goal. As the core of the programme evolves around individual goals, careful attention is paid to each person's progress, during every session.

'Last year we set weekly goals, and we encouraged the group to hold each other accountable for these goals and when clients weren't coming in. What I really appreciated was that they were honest when they couldn't achieve it. What we then did was look

at well why couldn't we? What were the challenges? Is it worth achieving it? And not me as the facilitator but getting the rest of the group to suggest ways of achieving that goal for the person, or getting someone to assist them and say "ok today or this week I'm going to help you achieve that goal". So creating support amongst the users, and getting the users to develop their own ways of getting to their goals or achieving their goals.' — P8

Asmentioned, facilitators and their groups can adapt the groups according to their situations and capacities. Each of the facilitators in this case study really gave their own flavour to the groups.

'I personally think that (i.e. personal strengths) is the most important session. I follow the strengths perspective in any work I do. In any negative there is always a positive, and it's getting the guys to understand that while I'm using substances and I'm mistreating people and all of this, there's a strength that could possibly help you in the future. So we link the strengths right now to how it is going to aid in the future.' — P8.

'Sometimes the worksheets are not enough for the clients to understand. Also, you must remember, it is in English and most of our clients are Zulu speaking, so you have to translate from English to Zulu and spend more time on activities [...] you tend to individualise it so that it will meet the needs of each and every client [...] For them to understand things they need to do them, like physically. They need to write something down, they need activities. [...] That helps them to grab it. Unlike when you sit and when you talk about it.' — P3

The facilitator of one group spent careful attention to mindful meditation at the beginning of the group, really stressing the importance of being in the now and introspection. Another facilitator put more emphasis on making the groups playful to involve everyone in a fun way. In her group they played harm reduction Pictionary to get everyone familiar with the concept of harm reduction and to slowly move them towards awareness of harm reduction opportunities in their own lives. Thus, the groups are quite flexible in responding to the facilitator's style and group's needs, as long as the facilitator remains aware of the purpose of the group, and the participants' progress.

Image 11: Contemplation room in Durban

Aside from pragmatic progress evaluation with all participants, which takes place during the group sessions, the groups can also be evaluated on their outcome. A pre/post interview manual has been developed for this purpose. In these interviews participants are, among others, asked about their drug use behaviour and perspectives on their use. The manual has been developed with the intention to interview prior to starting the groups, after completing the groups, and 90 days later, but a simpler evaluation can suffice as well. For example, the TB hospital asks its participants to answer 7 questions after completing the contemplation groups. Although their actual behaviour has not been monitored, respondents evaluated the groups very positively and reported more awareness and positive behaviour changes. At the time of this case study TB HIV Care had not yet evaluated their group sessions, other than through face to face (unrecorded) evaluations with its participants, and Hope House evaluations were no longer accessible.

Staff and finances
Basically, all you need for this intervention is a room that is safe and private, and one or two facilitators. Although it is helpful if the facilitator has some psychological training, the group can be facilitated by either a therapist, a counsellor or a peer. Just as long as the facilitator can steer and support the

group in a non-judgmental way. Among others, the facilitator should be able to address ambivalence, help participants to see a positive future, shed light on discrepancies, emphasise free choice, and identify and respond to risks (Shelly, Mac Donnell, and Sedick 2017). The table above demonstrates who facilitates the groups at the three different organisations in this case study.

At Hope House contemplation groups were at the core of their activities. In 2014 they ran these (and other) groups along with individual counselling for the annual cost of €44,382.02.[9] The vast majority of the costs were staff costs. Material costs included rent, electricity, printing, phone and internet, reading materials, transport reimbursements, refreshments and contingency rewards for PWUS.

Moreover, with the intention of expanding the running of contemplation groups at TB HIV Care and other locations in South Africa, the founder of the groups developed a conceptual basic budget overview in 2018. In this plan the costs of the groups were separated from other services, reducing the costs in comparison to Hope House. According to this concept two contemplation groups can be run

twice a week under the supervision of a psychologist for the annual cost of € 26,076.78.[10] The material costs in this budget plan overlap largely with the expenses made at Hope House. Differences are that the conceptual budget excludes management costs and transportation reimbursements, while it includes expenses for a peer and peer review learning.

The three organisations working with contemplation groups were/are all funded differently.

Teaming up

Lastly, as can be said for many other – if not all – services, the contemplation groups are most effective when they are part of a broader offer of harm reduction, healthcare and social services. Aside from group sessions individuals should also be offered individual counselling, and – during the groups – the facilitator assesses 'group members for appropriate interventions according to individual needs as part of the multi-disciplinary team' (Shelly, Mac Donnell, and Sedick 2017).

Between late 2012 and 2015, at Hope House one counsellor was primarily responsible for the group sessions, which not only included contemplation,

Table 4: Staff involved

Hope House	DP Marais	TB HIV Care
One facilitator and one co-facilitator were responsible for the groups. The facilitator was usually a group-counsellor.	Two occupational therapists are responsible for the groups. The organise the groups together. Each session one facilitates and the other co-facilitates.	One counsellor facilitates the groups. In Durban, they are training two students to take this over. Also, possible plans to train peers to facilitate the groups themselves.

Table 5: Yearly costs

Year	Location	Staff costs	Material costs	Total costs
2014	Hope House	€ 30,037.45	€14,344.57	€ 44,382.02
2018	Conceptual	€ 11,919.48	€ 14,157.30	€ 26,076.78

Table 6: Funders

Hope House	DP Marais	TB HIV Care
Hope House, where groups formed an essential core of its activities was funded by national funding through the department of social development, lottery funds, and some private donations.	Two occupational therapists are both funded through the Western Cape Department of Health, as part of TB hospital care.	Up to 2018 the groups through Bridging the gaps and the facilities, meaning primarily the meeting room, through a combination of international donors. In 2018 the municipality also started supporting the groups financially, through a subcontract with the Central City Improvement District (CCID).

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9   €1 = R16.02 (South African Rand)

10   €1 = R16.02 (South African Rand)

but also life skills, arts and sports and therapy, and a second counsellor had predominant responsibility over the individual sessions. Everything was offered as a whole.

'They were encouraged to have individual sessions, in conjunction with their group sessions. And most of them did. [...] And everything was contemplation based, so not just the groups. Our counselling sessions were very much around motivation to change: what is your motivation to change? what can you change what can't you change? [...] In their communities they didn't necessarily have options to change big things; They weren't able to, you know, move cities or suddenly go to Varsity. Those options just aren't available because of the socio-economic situation. So, we worked a lot around lifestyle changes that they did have control over. And by default, their substance use fell into that category because that was something they could change.' — P2

All four locations in this case study offer various different group sessions as well as individual support and counselling. Individuals may for instance receive social support in getting a new ID, finding a job or referrals to a housing shelter. At the TB Hospital and TB HIV Care PWUD can earn a small amount of money in occupational programmes. At the hospital the patients can earn some money, either through ironing or a car wash for the hospital staff; at TB HIV Care there are clean ups three times a week, during which a team of PWUD goes out to clean the streets.

At the TB hospital the contemplation groups are part of OT sessions. Patients staying in the hospital for their TB treatment – usually for several months – can attend these sessions, save some money through the abovementioned work, get help from a social worker, aside from the medical treatment they receive from doctors and nurses.

Apart from the abovementioned social and occupational support, at TB HIV Care PWUD have access to services such as HIV and TB testing, HCV, HIV and TB treatment referrals, condoms and clean needles. For those who combine their stimulants with heroin there is the possibility to receive methadone. Although at the time of this case study methadone treatment is still a pilot programme, and it is unsure whether this will be continued late 2018. They also work together with several other services.

For instance, in Cape Town, on referral PWUD can get jobs in gardening and restaurant work, through a project called Street Scapes. Also, TB HIV Care collaborates with the Central City Improvement District (CCID), who not only refers PWUD to their services, but also helps with referrals to a shelter or clinic. There are several detox clinics with which TB HIV works together, from some they even receive relevant updates. Beforehand, TB HIV Care's staff help individuals prepare.

'If they want to get into a treatment centre we help them develop skills toward substance change before they go to a treatment centre.' — P8

Successes and challenges

Although the successes of contemplation groups are hard to prove in a quantitative manner and its effects cannot be considered separate from the other interventions with which it is integrated, both PWUS and professionals report multiple positive outcomes. Aiming to be as flexible, individual and realistic as possible, the group's successes are about making small steps, slowly moving from contemplation to action, or even just challenging someone's hardwired thoughts.

'It really did help me. It helps you to map out where you want to be. Its not immediate, it's a step by step thing. It's all in phases. It helps you map where you want to be the next week from here. [...] No other place helped me exclusively focus on myself and where I want to be. They make you ask those questions. [...] We didn't like it at first, but we had to do it in the programme. The groups and the broader programme told me how to manage my drug use. Without it I wouldn't be here. For me it was vital. Before that I never heard of managing my drugs before.' — SU1 (and SU2)

'I saw lifestyle changes, reuniting with families, leaving gangs they had been involved in for years, being accountable, taking responsibility for any problems they had with the law. [...] It gives them an opportunity to stop and think wat they want.' — P6

'Some of them have abstained from using substances. Others have changed their administration. They have moved from injecting to smoking. [...] We've also seen, like I said, a lot of development in terms of reconnecting with the family. Setting goals

that are realistic, they've been doing, and they want us to hold them accountable to it.' — P8

Moreover, the groups have proven to be an effective low-threshold intervention in a culture that primarily tends towards an abstinence approach. The intervention's guidelines offer handholds to staff members in how to work with a contemplative harm reduction approach, thereby supporting a transition to less coercive treatment and support structures.

The latter success automatically leads us to one of the intervention's challenges. Whereas the groups provide for excellent contemplation and harm reduction handholds a general lack of understanding of harm reduction and a coercive abstinence approach in other PWUS services can interfere with the effectiveness of the groups. For example, when service users are stimulated to reflect and make individual decisions about how they want to use, but their doctor, nurse or counsellor tells them abstinence is the only way.

Another challenge is keeping true to the groups objective, while remaining flexible and responsive to the needs of the group. Some parts of the group sessions might be hard for the facilitator to offer, such as meditation guidance or steering the group in the individual strengths sessions. On the other hand, the group participants might want more active and less wordy group sessions. Even the word *Contemplation* can be difficult to work with, and some of the sessions are a little word heavy in the guidelines. In practice, groups have worked around this, for instance by adding more interactive components to the meetings and changing some of the language used. However, this requires careful reflection and evaluation whether the essence of the group is maintained.

Moving forward

First of all, and most importantly, in conversation various PWUS have not only expressed the value of the contemplation groups in the past, but also their interest for more of these groups in the future.

'we need to have a sense that we belong somewhere, we need to have a sense of purpose. Even though we hate change, even though we don't like initial change. You also need to be able to sit with yourself

and tell yourself "you know what, you fucked up on this, you really did, now move on."' — SU3

In a focus group session with ten *Tik* users a general interest for contemplation groups is expressed, and some concrete topics, such as how to deal with anger and improve family relationships are mentioned. In a later interview, two PWUS not merely express an interest attending future groups, but also in facilitating them.

'I hope that there's more, because I know what it meant to me, and I would like other persons to experience that. And if it does occur that there are more of these groups, I think SU1 and I, having been the pioneers and having the experience and having the relationship with drug users, we avail ourselves to these kind of groups in any which way. [...] We want to be involved (SU2). I would like the groups to go on, because I actually think maybe I could do with a bit more contemplation groups, because I kind of slipped on the things that I learned back then. [...] I dropped a ball there (SU1). I'm all for these contemplation groups or any other group that can add value and positivity to drug users. [...] I would like to impart the knowledge and experience to other drug users as a facilitator (SU2).' — SU1 and SU2

At the TB hospital the occupational therapists intend to continue offering the group sessions as part of their broader OT programme. Moreover, the researcher who was involved in the start of contemplation groups at the hospital mentions that she -together with a small team – is exploring the possibilities to expand the contemplation groups to TB clinics and to one of the major drug treatment facilities in Cape Town. Such an expansion would greatly increase continuity of services and expectantly harm reduction results for PWUD. While parties seem interested it is mainly a matter of funding, not only for the implementation of the groups, but also for a greater transition towards an organisational understanding of harm reduction, and monitoring and evaluation of the process.

At TB HIV Care it remains to be seen if they can continue to offer the contemplation groups in the context of OST, as this is a pilot project, which will be evaluated late summer 2018. Despite this financial insecurity the organisation aims to offer the groups structurally in Durban and Cape Town. At both

locations they continue to work on the development of the content of the groups and in Cape Town they are looking for a way to offer the groups in a clear, accessible and integrated manner. Recent funding of a structured programme of which the contemplation groups form part through the Cape Town municipality provides for some opportunity to safeguard their structured continuity and integration with other services.

One specific ambition for the groups worth mentioning is the plan to work more with peer evaluation, with the intention to have peers working on and testing the programme in the next development phase.

Furthermore, the groups will start running in Pretoria as part of their Community Oriented Substance Use Programme. And any organisation interested in running contemplation groups can request the group's guidelines, the worksheets for each separate session, pre/post interview guidelines, goal sheets or individual advisory support where necessary.

LESSONS LEARNED

1 All you need for this intervention is a safe space and a facilitator. This does not have to be a psychologist but can also be a peer. As long as the facilitator is capable of supporting the group dynamic and individual contemplations, regardless of what phase the PWUD is in.

2 The groups are open and flexible on the one hand, making them low-threshold, and on the other hand, they feed into a strong group feeling, where a sense of family may arise and where service users hold each other accountable for their behaviour. While experience has demonstrated both can exist simultaneously this may require some manoeuvring and adjustments as each group develops.

3 These groups can be a good harm reduction starting point in more abstinent oriented environments. Although the impact of the groups certainly improves when it is integrated with other services, they can also run complementary to abstinence treatment services, being cost-efficient and not so politically sensitive.

5.4 COUNTERfit
An approach to safer smoking kits in Canada

'This notion that the quality of what you use to smoke with matters, because it actually impacts your health, is a level of engagement when people are not at all thinking about treatment. There is a not so subtle message that you matter, your health matters. What you do, even if it is criminalised or stigmatised, matters to us and we think that you deserve something better.' — P2

This chapter highlights a harm reduction practice that aims to better serve people who smoke stimulants, namely crack cocaine and methamphetamine, in Toronto, Canada. COUNTERfit is a harm reduction programme based out of the South Riverdale Community Health Centre (SRCHC), offers a range of different programmes aimed at meeting the health and social needs of PWUD, in various ways and through multiple venues. Specifically, we will look at COUNTERfit's safer crack and meth smoking kit distribution programme.

Canada
Canada, the second largest country in the world, has a population of 37 million people and is geographically divided up into ten provinces and three territories which are governed by three levels of government: federal, provincial, and municipal. The population is highly urbanised, 82% of the population is centred in large and medium sized cities along the Canada-US border. It is known as one of the most ethnically diverse and multicultural nations, with approximately 22% of Canadians identifying as immigrants. This results in a population with various ethnocultural backgrounds, bilingual status at the Federal level (English and French) and religious diversity. 4% of the population identifies as Aboriginal (a group defined by Inuit, Metis, and First Nation populations) (Statistics Canada 2017). Just under 5 million Canadians live below the poverty line, with children, single-mother families, Aboriginals, the mentally and physically challenged, recent immigrants, and PWUD making up the

Image 14: Toronto, Canada

majority of this group (Statistics Canada 2017). Canada boasts a nationwide health care programme wherein all provinces and territories fund and provide basic medical care to all its citizens, although it is not uncommon for Canadians to have additional private healthcare. One in three Canadians live in the province of Ontario, the most populated city in this province is Toronto with just under 3 million residents. Toronto is considered one of the most diverse cities globally with 49% of the population identifying as a visible minority[11].

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11   Persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour.

Substance use in Canada

The Canadian Tobacco, Alcohol and Drugs Survey (CTADS) is a survey of the Canadian population over fifteen years of age (residents of the three territories and institutions excluded). The data complements national and provincial strategies and programmes that aim to address drug use trends. The most recent survey in 2015 indicated that 13% of Canadians (3.7 million) have used one of the six following substances in the past year: cannabis, cocaine HCl or crack, ecstasy, speed or methamphetamines, hallucinogens, or heroin. 2015 witnessed a two percent increase of usage from the previous year (Statistics Canada 2016). Overall, Canadians between 15 and 24 years old had a higher prevalence rate than those over 24 years of age, and rates of use of those six substances were higher amongst men than women (15% to 10%) (Statistics Canada 2016).

Focusing on the category of stimulant use, 1% of the population said to have used a stimulant in 2015, which was similar to the statistic in 2013. Specifically, cocaine HCl or crack use prevalence was 1.2% and speed/methamphetamine use 0.2% of the total population. There was no difference in prevalence between men and woman who use stimulants (Statistics Canada 2016).

It appears that PWUD don't necessarily stick to one method of administration. In a 2014 survey among PWID in four cities across the country, Toronto included, over half the respondents indicated that they had either smoked or injected crack in the past 6 months (SRCHC 2014). In Toronto specifically, more than three quarters (78.7%) of PWID had also smoked crack in the past six months (ibid).

According to a 2014 survey, approximately 73% of COUNTERfit service users use stimulant drugs, the most commonly used drug is cocaine (SRCHC 2014). In 2012, 93% of the people using cocaine were smoking crack, while one third (33%) of people were injecting and nearly half (48%) snorting cocaine (SRCHC 2014). Moreover, this survey found that most service users (around 90%) were engaging in polydrug use. The most frequently used combinations involved alcohol, crack, and cannabis.

Currently, Canada is dealing with an opioid crisis – close to 4.000 people died last year due to opioid overdose. 72% of these accidental deaths involved fentanyl, a synthetic painkiller 50 times more potent than heroin (Special Advisory Committee on the Epidemic of Opioid Overdoses 2018). Throughout the country, cocaine has found to be laced with fentanyl and people who smoke crack are some of the most vulnerable groups, as they are unknowingly smoking the deadly opioid, not the stimulant they believe it to be. In order to help keep their community safe, COUNTERfit's harm reduction programme issued a warning to their service users and highlighted their free Naloxone kits.

Image 13: COUNTERfit logo

Drug policy and harm reduction

In 2016, The Ministry of Health reformed the Canadian Anti-Drug Strategy to become the Canadian Drugs and Substances Strategy. This national strategy rests on four pillars: prevention, treatment, harm reduction, and enforcement and is backed by evidence-based finding (Government of Canada, n.d.). Their harm reduction approach ensures that there are supporting measures that reduce the negative consequences of drug use. It also seeks to improve the health of substance users and connect them with other drug related health services. The Canadian government pledges to reduce the harms associated with substance use by increasing access to Naloxone which reverses opioid overdoses, streamlining the application process for communities that want to open supervised drug consumption rooms, supporting front-line harm reduction interventions to decrease the risk of sexually transmitted and blood borne infections that can be passed via sharing drug use equipment (such as straws, needles, and pipes and stems), and develop harm reduction measures that target Canada's Indigenous populations. Moreover, they support continued research on harm reduction via the

Canadian Research Initiative in Substance Misuse (CRISM), which is a cross country consortium that focuses on knowledge translation and implementation of research on drug use (Canadian Institutes of Healthcare Research 2017).

Origins of COUNTERfit

The COUNTERfit programme is based out of the SRCHC in the eastern part of Toronto. Established over forty years ago, the SRCHC is committed to providing primary health care services and health promotion programmes to east-end Toronto residents. One of SRCHC's most well-known areas of focus is harm reduction, as exemplified by the well-known and awarded COUNTERfit programme. Via COUNTERfit, SRCHC is one of three sites across Toronto selected to offer supervised injection services. The COUNTERfit harm reduction programme was the first programme in Canada to address the needs of non-injectors by being the first agency in the country to distribute kits for safer crack and meth smoking.

COUNTERfit started in 1998, as a response to alarming rates of HIV in large Canadian urban centres found in Toronto, Vancouver, Montreal, and Ottawa. Unlike British Columbia's Vancouver, where the injection drug using population is heavily concentrated in a specific and defined neighbourhood (East Hastings), Toronto's PWIDs are more spread out, distributed in different pockets throughout the sprawling city. It became apparent that a distribution model, as opposed to a centralized health unit mode, would best serve the drug using community. In response to this, outreach services were set up to meet the PWID where they are located throughout the downtown area. Via the AIDS Bureau of Ontario and the Ministry of Health and Long Term Care, a committee was formed to find out which Toronto neighbourhoods had the highest demand for harm reduction services. This committee identified South Riverdale as a community in need of harm reduction services for PWID.

The SRCHC harm reduction programme was formed with one full time outreach worker, the late Raffi Balian, at the end of 1998. The following year, the SRCHC harm reduction programme was formally named COUNTERfit, alluding to being able to get your *fits* (injection materials) at a counter. The satellite programme started in 1999 and was operated by volunteers until 2010, when it assured city

funding. By 2000, a team of three outreach workers was distributing almost 40.000 sterile needles and collecting around 30.000 used ones yearly. In 2006, COUNTERfit expanded its outreach to 7 days a week, including evenings with its mobile outreach delivery services. Female focused activities started in 2007 and expanded to a women's breakfast drop-in a year later. In 2008 a cooking group and a programme to deal with grief and loss started. The COUNTERfit programme grew from seven service users in 1998 to 818 in 2007 and 1163 in 2015, plus 2000 people who use their services anonymously. In June 2013, COUNTERfit unveiled a memorial for PWUD, the first of its kind in North America. In 2017 the programme had more than 22.000 service user visits and distributed close to 49.000 safer smoking kits. That same year, SRCHC also celebrated receiving Health Canada's federal exemption for supervised injection services and thus the first *Drug War Free Zone* in Ontario was born.

Out of the estimated 30.000 injection drug users in the Toronto area at the turn of the 21th century, 70% reported smoking crack cocaine as well, pointing to a significant overlap of injection drug users who also inhale their stimulants. Armed with this knowledge, in 2000, COUNTERfit began outreach and harm reduction interventions with crack cocaine smokers. Specifically, there was an evaluation needs pilot project for inhalation users who smoke cocaine (as this was and still is the drug of choice by most of COUNTERfit's inhalation services users) called the Safer Crack Use Coalition (SCUC). Comprised of street health agencies like SRCHC, the HIV/AIDS Harm Reduction Network, and the Harm Reduction Task Force, this was a coalition that asked PWUD in the streets in the Eastern part of the city what they wanted to see offered in terms of supplies and services by distributing sterile metal pipes assembled by volunteers and asking for feedback. The community involvement in the development of the safer crack smoking kits was a success, and almost immediately, these safer crack smoking kits were adopted by SRCHC and other Toronto agencies. Specifically, this evaluation and research tool of asking people what their needs were for safer inhalation equipment led to the production of the Pyrex pipe currently being distributed in COUNTERfit's safer smoking kits.

Image 15: Examples of toxic pipes people were using before the safer smoking kits were issued: tin cans, Ginseng glass bottles, water bottles, inhalers, car antennas

Before the metal pipes were developed for the pilot programme, stimulant users were smoking their crack cocaine through various toxic makeshift pipes, pictured above. The problem with these was that they would have jagged edges and heat up extremely fast, thus burning and cutting the lips and mouths of the user. Showing stimulant smokers' injuries resulting from these 'bad' pipes was enough to make the epidemiological argument to the Ministry of Health and Long Term Care that there was a need to protect this population from contracting contagious viruses like HIV and Hepatitis B and C and could be done via the distribution of individual mouth pieces and Pyrex stems.

In practice

Nowadays, COUNTERfit offers a range of different harm reduction programmes aimed at meeting the health and social needs of PWUD. Specifically, there are three ways in which PWUD can access safer smoking materials: at the COUNTERfit office (fixed site), by a peer-run off hours delivery service (mobile outreach services) and at the homes of trained service users in their network (community- or agency-based satellite services). Via these three routes, COUNTERfit handed out 400.000 syringes and 67.500 crack stems in 2017. All these services are free for service users. All COUNTERfit services offer the option of service users becoming registered, with the intention of tracking which services they are using. This is useful in reporting, but even more so for identifying community members who are doing secondary distribution from their local area. For example, this affords them the option of potential employment with those service users in the Satellite program.

At the COUNTERfit fixed site, service users can access harm reduction supplies, information, harm reduction-based counselling, and confidential referrals to other health and social services and supports such as treatment, detox, counsellors, and shelters. The fixed site and its services are open from 9AM to 5PM during weekdays and duties are carried out by COUNTERfit workers, assistants, and volunteers. The profile of a fixed site user is heterosexual, male, 50 years or older, homeless or under-housed[12], living off social assistance benefits, has a history of petty crime and smokes crack cocaine on a daily basis – although crystal meth and opioids are also used. In a 2014 study, it was reported that the fixed site is COUNTERfit's most widely used service (SRCHC 2014).

We spoke with one participant who has made daily visits to the fixed site for his safer smoking supplies, since they opened 20 years ago. Over this time period, he has seen the programme develop a holistic approach towards issues for PWUD and grow in terms of service users and programmes on offer. Personally, this programme has helped him develop his social, learning, and leadership skills, making his connection to this service

'one of the best things that's ever happened.' — SU1

Another service user who participated in this case study started visiting the fixed site in order to get safer injection supplies for his friend group that injects. He was,

'tired of seeing them use dirty needles and decided to act.' — SU4

He became familiar with the materials needed for safer injection, including training on administrating Naloxone in case of an opiate overdose. In the meantime, he discovered that he could also get safer smoking supplies for himself, although he does that much less regularly than collecting supplies for his network, as he, like the majority of crack smokers, does not share his pipe with others. It is striking that

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12   Term used by interviewees

although they have had their lives saved by Naloxone and continue to use the COUNTERfit safer injection kits, none of his contacts expressed any interest in making a personal contact to the fixed site, something he attributed to laziness, shyness, paranoia, or embarrassment. Accessing this service has made his network safer and healthier and helps him to support his friends that inject.

COUNTERfit's mobile programme delivers harm reduction supplies, mainly safer smoking and injecting kits, to callers during evenings and weekends when the fixed site is closed. This service is available all year round, from 6PM to 12AM on weeknights and from 12PM to 12AM on weekends and holidays. Service users can order both sterile needles and smoking equipment for free from the mobile unit, and the outreach workers aim at delivering the order within 15 to 30 minutes after receiving a call. Drop off locations need not be a house address, as many of their callers are homeless, staff will also come with supplies to bars or an intersection. The mobile unit provides a low-barrier, accessible venue for people to access harm reduction materials, support, and information in the places they live and gather. All supply packages come with a harm reduction insert, mobile service numbers, and if requested, a *bad date book*. The latter being a resource that allows sex workers to write down their negative encounters with clients and share with others to warn them. Approximately half the clients do not ask for mouth pieces when getting new supplies, reaffirming the notion that users don't like to share their pipes with others.

Two mobile service outreach workers were interviewed on their personal experiences with the programme. One participant saw her role as:

'[to] *provide anything they need to use drugs safely and help prevent the spread of disease.*' — P4

The other believes that:

'*everyone should offer what they can to their society.*' — P5

In addition to distributing safer smoking kits, the mobile outreach service providers also collect used needles. This need was illustrated by one outreach worker:

'*What do you do if you are in a wheelchair, and you want to get rid of your needles, but you can't leave the house? We serve that need.*' — P4

As a result of this service, the non-drug using community is supportive of this service that ensures used needles are disposed of properly.

Typically, workers wait at home for calls, and have supplies on hand there and make deliveries within the following catchment area, although the two mobile service users who we spoke to said that they regularly make deliveries outside the predefined outreach area.
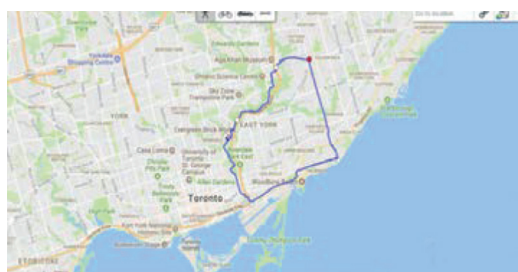

Image 16: Outreach work area

The professionals found it difficult to describe the characteristics (for example, age, gender, ethnicity) of their callers, as PWUD can come from:

'*all segments of society*' and that using drugs '*has no boundaries, nobody is immune from it.*' — P5 and P4

PWUD have the option to remain anonymous service users, but most of the delivery supplies are registered with the program to keep track of the distribution numbers and service users. This helps COUNTERfit not only to track their supplies, but it also keeps tabs on the whereabouts of their clients. For example, staff can track if a regular service user is not heard from in some time and act accordingly. When this programme was first offered in 1999, workers would go into their clients houses with supplies, now, however, management requires that callers come outside and meet them in their cars. The exception for this is if the caller is a new client and they feel like the need to go inside and demonstrate how the materials should be used safely and provide harm reduction material. Harm

reduction material related to smoking is available upon request, otherwise only safer use equipment is delivered. For safety reasons, the delivery location is always shared with an outside source. However, both outreach workers have always felt safe while on the job and explained that people are just happy to see them arrive.

The programme also counts ten community-based satellite sites, which are run by trained people with lived experience. The funding pays the satellite site workers and an organiser who coordinates the delivery of supplies and supervises the satellite site workers. All satellite site workers are long-term clients of the COUNTERfit programme and currently use drugs themselves (Strike and Kolla 2013). These paid peers are required to receive ten training sessions each year on a variety of issues including correct use and distribution of harm reduction supplies, basics of harm reduction education, basic needle exchange protocol, management of overdose, conflict de-escalation, suicide prevention, and training topics suggested by the satellite site workers themselves. In the satellite programme, peers deliver harm reduction supplies (such as safer sex, injection and smoking supplies), information and supports from their own homes. In this context, satellite sites may be the first point of contact where new clients learn about harm reduction practices, the COUNTERfit programme, or SHCRC itself. They extend the geographic and temporal reach and coverage of the fixed site to new networks of clients (ibid). These sites can also help to be low-threshold points of entry into the more formal social and health care systems, by building links with satellite users who are not currently using primary care services. As well, these satellite services provide an opportunity to teach proper smoking techniques in real time to service users, as they also serve as consumption rooms. Furthermore, the satellite sites are able to provide continuous services, as Strike and Kolla (2013) found that many of the workers teach their spouses and close friends to provide services when they themselves are not available (sleeping, or at a training, for example). In 2013, the satellite programme distributed almost 20% of all of the COUNTERfit safer use equipment for injectors and smokers and 20% of their condoms (ibid). Data on smoking kits or later data was not available at the time of publishing.

Three out of ten satellite sites are service-based. This means that COUNTERfit's satellite services are formed through partnerships with ancillary programs in the South Riverdale neighbourhood that work with PWUD, but have no funding for harm reduction programming. The satellite worker goes to the other organisation, a social housing provider for example, and makes connections, gives referrals, and/or distributes supplies. Regardless of where the satellite service is set up, this partnership is greatly beneficial to both parties:

'[the peers] are hired because they are already doing the work and distribution to their social network and already natural leaders. In that COUNTERfit encourages and supports that.' — P1

While representing COUNTERfit either via the Mobile or Satellite services, all staff and volunteers are encouraged to carry an official COUNTERfit badge with them, indicating to-in most cases, the police-that they may be carrying used and new safer smoking or injecting supplies as part of their employment.

Image 17: Safer crack smoking kits, including COUNTERfit info, condoms, lubricant, alcoholic wipes, packages of brass stems (5 per package), bamboo poking stick

Programming at COUNTERfit goes beyond distribution, they offer several other free programmes that focus on community development-one specifically for women and one for all services users. COUNTERfit's Women's Harm Reduction Programme was created to address the unique needs and challenges of women who use illegal drugs and women who work in the sex trade. The

programme has a dedicated worker that facilitates the Women's Breakfast Drop-in and the Women's Circle.

The Women's Breakfast Drop-in is held weekly in a strictly women's only space on the top floor of SRCHC, where ten to fifteen women can socialise, eat breakfast, see a nurse or counsellor, and obtain health and harm reduction supplies, education, support, and referrals. Members are allowed to stay in the group for as long as they like. One programme coordinator interviewed noticed that many women tend to use alone or rely on their partners for drugs or related material, leaving them vulnerable to perhaps unsafe practices. Connecting women to other women in a social and supportive environment, she finds, empowers them in a way that allows them to develop stronger voices both inside the group and out.

The Women's Circle is a programme where women volunteer to put together safer sex and safer drug use kits while engaging in discussion and support. This consists of two separate group of five women in each closed group, which rotate meeting every other week. Examples of kits these women build and distribute are: large injections kits, single *one hit* kits, and *chasing the dragon* kits (foil and mouth pieces). A facilitator with lived experience is in charge of getting all the supplies for that session, overseeing the proper packaging of the kits, entering the kits into a database and, double checking them for quality assurance. The programme also offers to the ten women in the two groups sexual health education, STI testing, free pregnancy test kits and emergency contraception pills, basic needs and hygiene items (tampons, pads, underwear, etc.), counselling, advocacy, and referrals to diverse health and social supports.

As noted in the introduction, Canada has a significant population of Indigenous groups. COUNTERfit's women's programming supports and honours these marginalised women with the newly developed the Aboriginal Support Group for PWUD. This group gives women who use drugs – many of whom were raised in Canada's residential schools – the space to discuss how colonialisation has impacted them and their health, gives them access to traditional medicines, and resources to reconnect them to their culture via ceremony.

COUNTERfit's Common Ground programme is a programme that implements groups and activities aiming to address the social, health, and advocacy needs of PWUD by reducing social isolation, building social support networks among people with similar lived experiences, increasing self-esteem, providing opportunities for creative expression and skill-building. This programme offers the following: a weekly community kitchen drop-in group where members share nutritional and harm reduction information, discuss food insecurity issues facing the community, and prepare and share a meal together; the Grief and Loss Education and Action Project, which includes a 12-16 week closed support group for women who use drugs and who have had children apprehended by Children's Aid Services. Once women graduate from this program, they are encouraged to join the ongoing monthly group focused on education and action-oriented goals. There is also the Drug Users' Memorial Project, which was established to commemorate and honour community members who have died due to drug overdoses, poverty, violence and complications from HIV and Hepatitis C, which uses community arts initiatives to facilitate grieving, peer support, advocacy, and public awareness around preventable deaths resulting from punitive drug strategies.

COUNTERfit also publishes their own magazine, the Total Hype magazine, produced for and by PWUD with content submitted by the community, intending to provide harm reduction information, allow for creative expression and build self-esteem.

Staff and finances
The majority of the COUNTERfit's funding come from Ontario's Ministry of Health and Long Term Care, with some financial support coming from the municipal government of Toronto. Despite the fact that nationally approved best practices guidelines indicate that all provincial public health services should supply safer injecting and inhalation equipment, not all public health units in Ontario do so. While all public health units are provincially mandated to run needle syringe programmes, beyond that it's up to them. So, the Ministry of Health and Long Term Care created a provincial programme, the Ontario Harm Reduction Distribution programme, to provide and purchase- exclusively- all inhalation equipment in a central location so programmes, such as COUNTERfit, can order them directly and

not have to go through a public health unit. Thus, safer smoking distribution comes 100% from the provincial government. Currently, the majority of the 30 public health units in Ontario distributes safer smoking kits, but not all (CBC News 2007).

The province of Ontario recently allowed for the widespread distribution of crystal meth pipes to public health units in May of this year. This is great news for the larger community, however, in practice COUNTERfit had long been using part of their budget to purchase pipes (a custom-made pipe, developed on the basis of feedback from crystal meth users) from their crack cocaine Pyrex stem supplier.

COUNTERfit's harm reduction programme is made up of over 75 volunteers and 20 staff members, who's salaries are funded by the provincial government via the AIDS Bureau and the Toronto municipal government via their Urban Health Fund. It costs approximately 324,675 Euros[13] a year to sustain this harm reduction programme that services approximately 150 people a day. While the mobile outreach workers are paid for their work, they personally must cover 60% of their automobile-related costs, such as gas, which is a major financial worry for those interviewed. COUNTERfit's Mobile Outreach and Satellite programmes are a relatively low-cost delivery service, as there are no rent- and up-keep related costs, only those of the supplies and salaries of the workers. Specifically, the operational costs for the Satellite services include the satellite work salary (162 Euros a month per worker), harm reduction equipment, and storage containers.

Overall staff members indicated that there was financial stability, yet a few were sceptical and concerned about the impact the newly elected conservative party could have in regard to their funding and programming, particular, the overdose preventions sites. In April 2018 Ontario's Progressive Conservative leader stated to be strongly against supervised injection sites (The Canadian Press 2018).

Teaming up

There is a high level of support between COUNTERfit's distribution programme and their other programmes, and regardless of the specifics of the intervention, the core remains the same: to put the users' needs first. The common thread of harm reduction being the basis of all COUNTERfit programming ensures that no matter which service someone accesses, they will be treated with non-judgement, respect, and an understanding that they are in charge of the care they receive.

There is emphasis on taking lessons from outside the walls of SRCHC and sharing knowledge, experience, and resources with other community centres. Moreover, connecting and collaborating with other similar organisations is considered a key factor in the success of their harm reduction intervention. This can be seen with public speaking opportunities, trainings, and mentoring, but also with collaborations, as with the Safer Crack Use Collation. Furthermore, COUNTERfit's service-based satellite services allows them to connect with like-minded agencies in Toronto's East end and these networks prove to be mutually beneficial for both sides. For example, linking with external agencies widens

Table 7: Staff involved

Job title	Number	Fulltime/part time	Paid/volunteer
Project Coordinator	2	Full time	Paid
Outreach Worker	2	Part time	Paid
Project Assistant	1	Full time	Paid
Peer Outreach Worker	10	Part time	Paid
Satellite Site Organizer	1	Part time	Paid
Women's Harm Reduction Health Promoter	1	Full time	Paid
Relief Mobile Outreach Worker	1	Part time	Paid
Common Ground Program Worker	1	Full time	Paid
Fixed Site Support Worker	1	Part time	Paid

13   €1 = $1.54 (Canadian dollar)

COUNTERfit's distribution of safer smoking and injecting kits while also supporting smaller agencies in need of harm reductions services, all while simultaneously strengthening the communities of their target audience.

'We would rather let people see what works well than reinvent the wheel [...] because this is part of the movement part of harm reduction that others often miss, this is part of building community, it's about building a united response that's comprehensive it's not just about needles in and needles out.' — P3

Successes and challenges
The success of the COUNTERfit safer smoking distribution programme can be attributed to the following four practices. First, their innovative strategies of mobile and satellite services allow them to meet the needs of their service users and conveniently bring supplies directly to them. Second, relatedly, service users can essentially access safer smoking and injecting materials 24 hours a day, 7 days a week. Third, with the help of peer facilitators, they keep a rich data collection on their output of supplies, allowing them to see what services and materials are in demand and which perhaps need improvement. And lastly, but perhaps most importantly, all of COUNTERfit's programmes are based on client-based care, meaning the programmes are built around the services users' needs, not the other way around. It is the belief of COUNTERfit that the drug using population is a very enigmatic population. To better understand them, we need to continually ask what their needs are and design programmes to fit those needs. This rule of listening to, accepting, and meeting the needs of each service user individually requires a lot of flexibility, and is not without complications, but the approach *is*: ask the individual what they need. By catering programmes and services to the individual, COUNTERfit can be assured that the PWUD's particular needs are met.

'The success of our programme is a non-judgmental approach of meeting people where they are and demonstrating their quality of life and experience matters to us and that we would like to offer you something to improve your experience.' — P2

'We have the coolest crack kits around but that doesn't make us exciting. What makes us exciting is that we work around the social determinants of health so *if someone casually walks in for a crack kit and mentions something else that is happening in their lives, we will integrate that into our conversation and approach. They come in to get a crack pipe and we give them that but also more and that's just the way we deliver services.'* — P5

The COUNTERfit founder's personal conviction, and thus the very fabric of the harm reduction intervention, is firmly planted in the belief that every service user is a potential service provider. Each professional included in this case study emphasised the need for ongoing involvement of PWUD and asking them directly what they want to see in programmes and services. This includes their involvement in the process of implementing, developing, planning, execution, and evaluation of the programme.

Personal accounts also strongly demonstrate the success of the COUNTERfit distrtribution programme. It was found that the intervention of providing safer smoking kits allows for individuals to:

'be a safer user', *'have a safer network'* and be supported by staff *'that are very willing to help users in any way.'* — SU2, SU4 and SU1

One service user, who has been a member of the Women's Circle for nine years, the Grief and Loss Education and Action Project, and the Women's Breakfast Drop-in, expresses the successes of the programme as follows:

'I feel more protected, more confident in myself because I know that I can get things that I need here and I will always do drugs, they [drugs] will always be here, but I think I've achieved a lot by coming here' — SU3

Her partner mentioned that for some times, she was reusing her smoking materials, but since her involvement with COUNTERfit, she is now able to get new smoking supplies each time she comes into the fixed site and this makes her feel much safer.

Successes range from making contact with a potential yet apprehensive service user, to making sure a service user gets to their doctor's appointment, and anything in between. From the perspective of a staff member their achievement lies in connecting service users to a variety of health and social platforms:

'people do well not when they stop using drugs but when they have the tools to take care of themselves like connecting with health and social services and that is what we do.' — P6

The success of COUNTERfit can also be defined by what sets them apart from other public health harm reduction agencies, where people with lived experience tend to have a more marginal role, are not given payment or benefits, or their harm reduction programmes are isolated from the rest of the organisation. COUNTERfit offers meaningful PWUD involvement and a direct response to community needs, giving staff the ability to act quickly, and more accountability towards the community.

From the perspective of the mobile outreach workers, the programme's success is as simple as making all your deliveries as fast as you can and:

'going to bed knowing no one will overdose or get sick.' — P4

A study conducted in 2014 to assess the success and efficiency of the mobile outreach services found that service users were happy with the materials delivered, delivery hours, information about smoking and injection given by staff, the relationship with staff, and referrals to other services. Moreover, the study showed that the programme was effective in increasing access to harm reduction services and safe equipment, providing harm reduction education, and reducing social isolation for its participants (Arkell 2014).
On the other hand, there are multiple challenges related to the distribution of safer smoking materials. The mobile outreach workers are on call from 6PM to 12AM evenings and weekends and this constant availability creates a difficult lifestyle for them. In connection to this, one worker said that he found it difficult to stay motivated while on call, as his schedule is unpredictable. Both mobile outreach workers echoed that the demand for their services were very high and they could not keep up with this demand and could *'never get there quick enough.'* (P4) and besides, sometimes run out of supplies during their shifts. P4 also expressed her frustration when service users would not pick up her phone call notifying them that she was outside with their delivery, thus causing delays in her schedule. She also struggles financially to maintain her car and pay for

gas, as the majority of these costs are to be covered by themselves. Finally, sometimes they encounter police in the area of their delivery and the decision whether or not to continue their order can be complicated. This serves as a reminder of the obstacles and stigmatisation they face from authority figures or those not familiar with COUNTERfit's mandate.

Other challenges related to reaching the target audience include insufficient turn over in the programming and insufficient trained staff, resulting in having to turn (potential) service users away from certain support groups. For example, the Women's Circle is quite popular and once the women are part of this social group they tend to not leave. While this speaks to the success of the intervention, it also creates year long waiting lists and disappointment for other women seeking out this resource.

Another practical challenge related to the distribution of safer smoking supplies is how to actually get potential service users to feel comfortable to first enter the SRCHC building. The east end of Toronto is gentrified and SRCHC's facade and appearance can be quite intimidating. It is presumed that some are reluctant to actually enter the fixed site.

Moving forward
When considering the future of COUNTERfit harm reduction programme, staff members, service users, and volunteers all are focused on one thing: the development and expansion of programmes and addressing the unmet needs of PWUD. One member of the Grief and Loss Education and Action programme noted that there should be a similar programme offered and directed at fathers and men who have lost children to the Children's Aid Society:

'I think they should look into having a programme for those men because they grieve just like us.' — SU3

Echoing the above sentiment, and as a direct response to the challenge of limited availability of some services, many service providers' hopes for the future includes more programming options and extended hours to better serve their community. Staff would like to see the women harm reduction programmes expand their opening hours even further to accommodate their target audience. For example, many female and trans sex workers are not awake during their breakfast drop-in hours

(9AM-12PM). These changes would engage the community on a more regular basis and that could have a significant impact on these women's lives.

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'I've got women who want to be doing something, anything, to keep them occupied and not thinking about going and getting their drugs, they want something else to do during the day.' – P7

One programme that staff would like to see develop is a Care Givers programme, targeting those caring for PWUD but who aren't familiar with their particular health or social needs. The idea here is to be a resource for say, parents of PWUD who have little or no experience with their children's lifestyle or substance use.

One remarkable development that was mentioned by a staff member and picked up by the media was the possibility of developing a project that would make hydromorphone, an opioid similar to heroin, available to long-time service users who have tried more traditional treatments such as methadone (Woo 2017). This would be a step away from replacement therapy but rather allowing the centre to offer clean, sterile substances as an alternative to poisoned street drugs in order to decrease overdose cases. However, it was noted that their priority is to make sure that all the basics of harm reduction are available to their service users before embarking on such a project.

There is no opportunity for COUNTERfit to open a safer smoking room as smoking is strictly prohibited in all buildings in the city. So, while safer injection rooms are spaces where drugs and their consumption are exempted by the government, safer smoking rooms cannot exist- for the moment.

Looking at the bigger picture, the programme would like to see the Federal government decriminalise all drugs and reroute policing and incarceration money to education, housing, income, health care and harm reduction support for PWUD.

LESSONS LEARNED

1. In terms of distribution: be ready for an unpredictable schedule, have enough supplies, keep a low profile when on delivery, keep good records and always give stimulant users options for their use.

2. In terms of service providers: make sure that you have something to offer service users, whether it be coffee, a warm meal, public transit tokens, or money in order to entice them to establish contact and stay connected to what you have to offer them.

3. In terms of organisation function: have a comprehensive and flexible harm reduction strategy infused into all services that allows you to look all the different ways you can intervene with harm reduction practices and policies for all kinds of users.

5.5 El Achique de Casavalle
An approach to drop-in centres in Uruguay

'The importance of [El Achique] is that [service users] have a place to come to, a reference point, where they're received whatever their situation, where they're helped; to resume their life, to move on or to start over again. Without judgment, without blame.' – P1

'We come to El Achique to relax, to calm our thoughts, to leave all the noise and problems behind. We create a family bond. We cook together, talk to each other. Here, we come and try to help each other.' – SU4

El Achique de Casavalle (Achique) is a community-based *listening, welcoming and proximity centre* that opened around 1998 in the north-eastern zone of Uruguay's capital, Montevideo. It's situated in the Casavalle basin, an area of Montevideo where over 55% of the households live under the poverty line (Suárez et al. 2014). Casavalle was one of the first places to experience an explosion of the use of *pasta base de cocaína* (*pasta base*), a South-American form of relatively raw smokable cocaine, in the early 2000s.

The drop-in centre's primary purpose is to work towards social integration, to provide social support and to improve the lives of vulnerable people, particularly young males, with problematic drug use within their own (or surrounding) neighbourhoods. Work reintegration is a secondary goal of Achique. Achique aims to generate a positive environment in which a SU can reduce exposure to life on the streets and to the drug use scene. Achique offers both individual and group psychotherapeutic counselling, (health) education, and other activities such as cooking classes, workshops on construction, relapse prevention, and basic rights, and in some instances, referrals to job opportunities if they present themselves. service users also get access to some other services that are available to PWUD within Uruguay's national network of drug care and treatment (RENADRO). Achique opens on weekdays at 9am and closes at 3pm and is closed during weekends. It is an interinstitutional intervention, supported by the State Health Services Administration,

Image 19: Montevideo, Uruguay

the Ministry of Social Development (MIDES), the Child and Adolescent Institute of Uruguay, and the local government of Montevideo.

Uruguay
Uruguay is a small South American country, wedged in between two huge neighbouring nations: Argentina and Brazil. To the east, it borders the Atlantic Ocean, and to the south, the Río de la Plata, the world's widest river mouth. It is home to roughly 3.5 million inhabitants, over half of whom live in the nation's

capital, Montevideo. Traditionally, and especially in comparison with other countries in Latin America, Uruguay is known for its relatively progressive social policies. In Latin America, it was the first country that allowed women to vote, only one out of two countries to have decriminalised abortion, and the first country to legalise same-sex civil unions (Walsh and Ramsey 2015). Uruguay has been a representative democracy since 1985, after having suffered a dictatorship for twelve years, between 1973 to 1985. José Mujica, president from 2010 to 2015 - when Uruguay legalised abortion, same-sex marriage and cannabis – had been imprisoned for 13 years during the dictatorship. The country is considered a high income country by the UN, and ranks first of all Latin American countries in democracy, lack of corruption, peace, and prosperity (U.S. Embassy of Montevideo 2013). Uruguay also scores high as a socially developed country according to the Social Progress Index, that combines indicators in the areas of basic human needs, foundations of well-being, and progress opportunities (Social Progress Index 2017). The large majority of problematic drug use takes place in the capital, Montevideo.

Substance use in Uruguay

Before the turn of the millennium, the large majority of problematic substance use in Uruguay was associated with cheap and easily available substances such as alcohol and inhalants (such as glue, *naphtha* or thinner) (Keuroglian, Ramírez, and Suárez 2017). The use of *pasta base* only became a public health issue in Uruguay relatively recently, during the economic crisis that hit the country in 2002 (Suárez et al. 2014). *Pasta base* more or less fully replaced other problematic substance use, such as cocaine injection (Observatorio Uruguayo de Drogas 2014). According to users, this problem emerged as a result of a breakdown in the sociocultural realm, a loss of traditional family values, combined with a lack of education and work opportunities (Suárez et al. 2014). Use of *pasta base* quickly affected the more vulnerable urban populations in low socioeconomic conditions, that some researchers liken to the *crack epidemic* in the US in the 1980s (Observatorio Uruguayo de Drogas 2014; Walsh and Ramsey 2015; Keuroglian, Ramírez, and Suárez 2017). However, in contrast to what happened in the US, the rapid increase in the use of (smokable) cocaine was not accompanied by a heavy increase of violence. In fact, Uruguay remains one of the safest countries in the region, although its citizens do feel relatively unsafe (Walsh and Ramsey 2015).

According to scientific estimations, Montevideo is home to an estimated 9,500 to 14,500 people who use *pasta base* problematically, of which roughly one third lives in the streets (Keuroglian, Ramírez, and Suárez 2017; Suárez et al. 2014). The large majority is male (89.4%), uses *pasta base* at least once a week (90%) and uses more than one substance, such as alcohol (79%), cannabis (75%), cocaine HCl (34%), or tranquilisers (21%) (Keuroglian, Ramírez, and Suárez 2017). Over half of the users consume *pasta base* individually, and the majority (63%) consumes the drug in the streets. HIV prevalence among people who use *pasta base* is 6.3%, which is high compared to the prevalence among the general population (0.45%) (Keuroglian, Ramírez, and Suárez 2017).

During interviews, both (medical) professionals and people who use *pasta base* frequently mentioned the intentional use of cannabis as a harm reduction method, although cannabis did not agree with all respondents. While most respondents agree that it never completely substitutes *pasta base* use, they do note that it helps them to cut down on or gain more control over their *pasta base* use. One respondent (SU6) explains: *'we try to use marijuana, not quite as a treatment method, but more as a way to chill, to come down, and to help avoid going after stronger drugs.'*

Respondents also mention that it helps reduce craving for *pasta base,* in part because the duration of the cannabis effects compares favourably to *pasta base*, which only lasts a couple of seconds, only making them want to smoke more. Another important contrast to the effects of *pasta base* is that cannabis stimulates their appetite and can be effective as a sleeping aid. Using cannabis also helps PWUD reduce their anxiety (particularly after extended periods use, although in some it actually stimulates anxiety and paranoia) by helping people detach from the self-centeredness of heavy *pasta* use, and by helping them to relax when they're too strung out.

'Pasta leaves you all by yourself, muted, quiet, without anyone, alone. Pasta you don't share. It makes you vicious, violent, aggressive. Now, [cannabis] is the complete opposite. It makes you want to share,

go out, to have fun, to talk, be with friends or family' — SU7.

Various respondents, including those working in the medical profession, mention either recommending cannabis or condoning its use (while not allowing the use of other substances such as alcohol or *pasta base*), and one expressed regret not being able to prescribe medicinal cannabis for the above reasons. However, another respondent mentioned that – weighing only 39 kilograms – she was prescribed medicinal cannabis to stimulate her appetite.

'There is this routine in the streets. You wake up, get high, lie down, get high, wake up, get high (all laugh). You don't eat, there's nothing else, you become like a stick, very thin. [...] Pasta takes away your hunger. I could stay like that for three days in a row: drug drug drug drug and I did not eat. Then you quickly become all bone, all skinny. Because you don't eat' — SU4.

Drug policy and harm reduction

Use of illicit substances and personal possession of *a minimum quantity* were never criminalised in Uruguay, including during the 1973 — 1985 Uruguay dictatorship. Since 2004, access to clean needles and syringes became regulated, and since then, harm reduction has increasingly become more integrated in the country's drug policy (Walsh and Ramsey 2015). In 2012, the government led by president José 'Pepe' Mujica proposed to fully regulate and control cannabis in the country, as part of his *Strategy for Life and Coexistence*. This strategy also included proposals to crack down on corruption and narcotrafficking, and expanding treatment for problematic drug use, particularly for *pasta base* (Walsh and Ramsey 2015). A prominent argument was the separation of drug markets, similar to the Dutch policy of tolerating cannabis sales in coffee shops. The idea being that limiting exposure of people who use cannabis to people that sell cocaine would decrease the use of *pasta base* (Walsh and Ramsey 2015). By the end of 2013, Law 19.172 was passed through government, allowing Uruguayan citizens (thus prohibiting access for foreigners) to acquire their cannabis through one of three ways: home cultivation (of up to six female plants); through a so-called *cannabis club* (cooperatives that allow 15 to 45 users to collectively grow up to 99 plants); or via the commercial sale of cannabis at pharmacies (Hudak, Ramsey, and Walsh

2018; Walsh and Ramsey 2015; Corda and Fusero 2016; Junta Nacional de Drogas 2016). The explicit purpose of the law is to reduce violence related to the illegal cannabis market, and to promote public health by treating problematic cannabis use, educating the public on the risks of cannabis, and reducing the harms associated with cannabis use (Walsh and Ramsey 2015; Hudak, Ramsey, and Walsh 2018). In the following years, activists pushed for further reform, arguing that while the law legally regulated possession amounts for the first time, PWUD were still subject to arbitrary arrests, could not legally purchase or cultivate cannabis, and were forced to purchase cannabis from *bocas* (local dealers) that also sell other drugs such as *pasta base* (Walsh and Ramsey 2015; Corda and Fusero 2016). Respondents in our study further argued they lacked (easy) access to pharmacies or cannabis clubs either because registration was too complicated or because pharmacies are too far away for those living in poor neighbourhoods. Access is easier for consumers from higher socio-economic classes. The result is that even if service users explicitly try to consume cannabis instead of *pasta base*, they end up consuming the latter instead, as explained by this respondent:

'Sometimes I feel like I better not use pasta, so I'm going down to the boca to buy weed in the same place they sell pasta. It is very problematic, because many times I end up consuming pasta. Because the corner, people you see, everything reminds you of your previous days of consumption. It is very complicated. Because you go for cannabis and you end up hooked to pasta' — SU3.

The interministerial National Drug Council is the body governmental responsible for its national drug policy, the National Strategy to Address the Drug Problem (END) 2016 — 2020. This is a human-rights, gender and public-health based approach, seeking a new form of market control and regulation' (Junta Nacional de Drogas 2016, 34). It understands the drug problem to be a complex issue comprising of economic, political and cultural factors. It requires a comprehensive approach focused on social integration and inclusion of vulnerable populations. The aim of Uruguay's national drug policy is to ensure access to people's fundamental right to integral health, focused on quality of life, health prevention and promotion, care, treatment, social inclusion and

harm reduction, while also promoting alternatives to imprisonment (Junta Nacional de Drogas 2016). Harm reduction is an explicit aim of both the national drug strategy and the Cannabis Law. Harm reduction extends towards the country's tobacco policy as well, and will also be the foundation for the future regulation of the alcohol market as well (Junta Nacional de Drogas 2016). Uruguay – and Montevideo in particular – offers a variety of services for PWUD. Prevention and harm reduction related services include 24-hour telephone assistance, outreach workers (*Aleros, El Abrojo*), residential treatment facilities, one van that offers mobile harm reduction services (*UMA)* in Montevideo's city centre *Ciudadelas* – centres that offer information, counselling, diagnosis and referral for the general population as well as PWUD.

Origins of El Achique

'[El Achique] is about finding a quiet space for when you're feeling bad, it's about finding refuge, leaving danger and madness behind.' — P1

Working in small local *policlínicas* [health clinic] in Montevideo's poorest areas around the turn of the millennium, a psychologist, sociologist, and a medical doctor witnessed the emergence of *pasta base* use, dealing, and related violence and crime. Attending to clients, they learned of relatives that were using, and started going out into the streets, making contact with street-based homeless PWUD, offering individual, group and family interventions in the streets. During this time, the conservative national government was firmly against harm reduction. However, as civil servant of the progressive municipal government of Montevideo, psychologist Claudia Crespo was allowed her to spend ten hours a week on this project, paving the way to set up a physical facility next to the health clinic to assist people who use *pasta base* in 2009. In 2012, the local government and the catholic church leased a building to El Achique that continues to be used today. The name 'El Achique de Casavalle' was invented by a user, from the Spanish *achicarse* (making oneself smaller), which in Uruguayan slang means something akin to chilling down, coming down to earth, taking it easy.

The majority of Achique's service users are young males, roughly between 18 and 35 years old, the majority of whom smoke *pasta base*. Many (also) consume cannabis and alcohol. According to respondents, injecting is presently very rare in Uruguay and none of the service users is a current or former PWID, although data is not registered structurally. While all service users live in the same or adjacent poor neighbourhoods, not all come from the lowest socio-economic backgrounds. In fact, most do have homes, although they do often have difficult family situations. During our visit in April 2018, only three of the current visitors did not have a roof over their head and slept in night shelters. Achique sees anywhere between ten to 25 service users a day, and up to (several) hundred a year.

'I started using cannabis when I was 12 years old, moved to basoco and tabasoco [a mixture of pasta base with cannabis and tobacco, respectively] at 17 years. At 20, I was using pure pasta, with ash, in a pipe.' — SU1

Achique is called a *community-based treatment centre*, based on the concept of Italian psychologist Efrem Milanese. The basic principle of such a centre is to offer a safe space and a healthy environment for people who are in a state of serious social exclusion. Its objective is to improve the living conditions of both the target population and of the local community. Community treatment takes into account the individual, their family relations and the community in which they live. This idea was put into practice by psychologist Crespo in the early days:

'[She] started working in proximity, in the community, with users, and with the community as well. This was totally new.' — P1

While the label *treatment centre* may suggest otherwise, Achique is firmly based on harm reduction principles, and respondents consider the interventions offered at Achique as much a *treatment* as they would medical or psychological interventions. Achique is about the construction of citizenship and creating novel social networks.

'It is about building citizenship, building a human being. There are many things they never had. They didn't lose them, they never had them in the first place. You have to help them discover their skills and abilities. Stimulating self-esteem and encouraging them, building on each one's strengths.' — P2

Service users are not formally involved in running the centre, since – as some respondents argue – this would create friction between service users. Their involvement includes preparing breakfast and lunch, cleaning and general maintenance; chores that are all considered part of the *treatment*.

In practice

Achique is housed in a long one-story building, with a small chapel in the back – which is only used for church services during weekends. It's a welcoming, low threshold drop-in centre, where service users can simply show up and join breakfast. Both breakfast and lunch are important elements of Achique. All meals are prepared by service users, for which they're complimented extensively. The meals are served and eaten as a group at a long table. Since many service users come from complicated social environments or broken homes, sitting together with other service users and staff to them feels much like having a meal with a real family.

'For many, this is the closest to a family they know. For many it's been ages since they sat down at a table to eat together.' — SU6

When new service users arrive, they are greeted as warmly and as casually as old timers, and safe for the fact that they introduce themselves, it would be impossible for an outsider to tell who's new and who's a regular. Various personal hygiene services, such as a (cold) shower and a toilet, are available to service users, but they can also cut each other's hair, wash their clothes or use hygiene products such as toothbrushes, deodorant, bars of soap and razors. Since service users are not judged and are always welcome, for many it is a place of reference, where they can come when they are not well, returning only in case they relapse.

The foundation of Achique is providing for the most basic needs of service users, such as hygiene, food, and warmth, interpersonal contact, and importantly, something other than the hazardous scene of drug use that many of them are constantly confronted with.

'The fundamental thing is to reduce the time that [service users] are exposed to risky situations. Whether on the streets or in complex family situations. Any place that is difficult, complex, and where

they are exposed to a lot of violence and a lot of drug use.' — P2

Image 20: The drop in centre

What makes Achique special, both professionals and service users agree on, is the warm, positive and welcoming atmosphere, and the solidarity between service users. service users regularly look out for one another, bringing gifts such as clothes for more underprivileged service users. Or, as several respondents confided, going out of their way to help another SU find a place to sleep in a night shelter.

'For me, the most important aspect of El Achique is family. We're all equals here, and we understand each other. Take me, for example: I don't have a family, no father, no mother, nothing. At El Achique, these are my siblings, my relatives. Sitting at the table to share meals, I love that.' — SU4

The concept is that by first creating a safe and welcoming space, service users can start working on various aspects of their personal and community-related issues. service users have access to both individual and group therapeutic interventions at the DIC itself, through the psychologists working there, and can be referred to many additional services as well (such as medical, psychological, psychiatric, dental service, but also access to educational and work programmes). Many service users don't have a purpose in life, and some of them demonstrate this visibly, hanging on couches and feeling reluctant to help wash dishes, clean the toilet or sweep the floors. service users are encouraged to explore their strengths and abilities, motivating them and stimulating their self-esteem, autonomy and eventually

independence. Respondents mention the importance of instilling on them they are much more than just a drug user.

'They teach you manners, learn to be sociable, talk to people, because when you're on drugs you do not talk to anyone. For example, I was always on the defensive, I felt like less than others. I feel fine now.' — SU5

Many of the activities at Achique are planned in such a way that service users gain experience in working together, being on time, dividing tasks. The aim is to promote inclusion, generate de-stigmatising and productive links with society through work and job training.

At Achique, there is a changing offer of courses and activities for users. Past activities have included percussion, boxing, capoeira, and chess (which service users really liked, and taught them skills such as practicing patience and not being impulsive). Other activities and courses were more directly linked with labour reintegration, like classes on computer use, carpentry, construction, growing vegetables in an organic garden, making (and selling) fresh pastas and breads.

'Here you learn things. All the time you learn. The habit of cleaning, of maintaining order, harmony, sitting at a table. Many have no family and sitting at the table with companion, chatting, is a great thing. There's joy here, we clean together, we listen to music together, we share our mate [the national beverage].' — SU1

Interestingly, substance use itself is not often an explicit topic of conversation. From its inception, Achique was intended as a place where people who have suffered (abuse, abandonment, family problems, violence, etc.) can address these issues rather than their substance use, which is considered a symptom of all types of (social) exclusion, of poverty and of violence. In terms of harm reduction strategies, psychologists at Achique dedicate a lot of time and attention to generating awareness around situations and contexts in which service users are much more vulnerable or exposed to risk, by reminding service users of strategies they themselves have used before (avoiding certain people or locations, for example).

'We try to leave all the drug problems outside the door. Here, we talk about normal things. Football, food, women... There is no talk of drugs here. We are aware that this place is to help us make progress.' — SU3

However, service users also mention that part of what they appreciate about Achique is the fact that cannabis isn't frowned upon, even if substance use is not allowed at the premises.

'This is the only place where they don't say that you can't use. They don't quite say 'go and smoke a joint' either, but our psychologist used to say: I'd prefer you to go out and smoke a joint, think about eating and drinking a coca-cola rather than smoking pasta base.' — SU5

An additional important objective has become to assist service users in (re)integrating them into the job market. This wasn't one of the initial objectives but has become quite important over time. Insertion into the work market is considered fundamental in the treatment process, since respondents consider full inclusion into society impossible for adults without access to work. Precisely because many service users have only sporadic and erratic work experience, they lack references, in addition to their substance use, (re)integration into the formal labour market is quite difficult to accomplish. During our visit to Achique, their kitchen was being renovated by service users, offered as a course under the supervision of a construction teacher. Achique also offers modules on how to avoid work-related accidents (such as the proper use of tools and safety items) as well as a first aid course. Further, service users have access to a lawyer that educates them on labour legislation and rights, an important item for people with little experience in a formal work environment. Moreover, many of the service users often have no more than primary education and few service users see the value in getting educated further.

With support from the National Drug Council and under guidance of a social worker, in 2013 several service users formed a small cooperative called *Achicando Caminos*. The cooperative is contracted by the State Sanitation Work Organisation (OSE) and provides several service users with a paid job

for a year. It has since become an independent organisation.

Staff and finances
The staffing at Achique has been subject to changes over the years. Up until October 2017, the project was run solely by one of the founders. Currently, Achique is staffed by two psychologists; one project manager (working from 9am to 3pm) and a project assistant (who works between 9am and 1pm). During our visit, a third staff member (also a psychologist) was unexpectedly added to the staff. The staff is paid by a cooperative that is contracted by RENADRO.

Of the funds that are currently available to Achique, RENADRO pays for human resources (salaries), and use of the building is loaned by the priest of the local chapel. Maintenance is covered by the municipality of Montevideo. Achique receives a small monthly amount from the National Drug Council to purchase basic commodities such as fresh food and cleaning materials. In addition, the organisation receives irregular donations from MIDES to purchase dry food stuffs. Courses are paid by the national institute for employment and vocational training. For additional funding, Achique has to apply for competitive funds at the National Drug Council that are earmarked for specific projects such as courses, but also for daily expenses such as food and transportation.

Teaming up
Achique is one element of the country's network of services for socially marginalised peoples. New visitors, especially those arriving independently (i.e. not through a referral) are usually first referred to the local health clinic for an assessment of any (mental) health issues. The following example illustrates this:

'When I first came to El Achique, I was feeling persecuted, paranoid, people looked at me weirdly. I was depressed, cut myself. [...] The psychologist [at Achique] told me: look, I think you have a personality disorder, you have to get treatment. I told her all about my childhood, everything. She told me she suspected I had this disorder since childhood. And

I never knew I had it, you know? In the beginning I didn't want to know anything about it. But then I started thinking about it and said, ok, I'll go. And the place they sent me [a residential treatment centre] was great. One of the best, and free! [...] Now I'm fine, I haven't touched a pipe for over a year.' — SU5

The Achique team can help service users connect with other medical and social services, such as GPs and dentists. They also help service users register for an ID card and a free public transport pass. Otherwise, Achique is relatively isolated in terms of direct connections to other services. Some respondents see this as the result of the mentality of the previous management, who consistently challenged state structures and bureaucracy.

'Something I see a lot with teams that work with marginalised people is that they themselves end up excluding. They take the side of the users, so if users have trouble reaching the medical system, the team ends up fighting the medical system as well. And it ends not in a spirit of cooperation but of competition.' — P4

Independently of Achique, service users have access to SACUDE: a municipal complex that aims to improve the quality of life of the residents of Casavalle, by promoting access to culture, sports and health. Service users can go to SACUDE to practice sports or work out, but also have access to other services, such as getting their national identification card, access a public jobs centre, or receive assistance for recently released prisoners. Respondents would welcome better links with the formal educational system, such as *technical* or vocational schools for service users that wish to complete or continue their education.

Successes and challenges
Since Achique provides attention according to the needs of each individual and is an open-ended intervention, several respondents mention that measuring success is complex. This is made more difficult as Achique does not systematically record

Table 8: El Achique staff

Project manager / psychologist	Part time, 9am – 3pm, paid
Psychologist	Part time, 9am – 3pm, paid
Psychologist	Part time, 9am – 1pm, paid

or monitor data of its service users. Nevertheless, respondents do mention various measures of success. For example, service users frequently manage to reduce, and in some case even completely quit, their drug use. Improvements in the quality of life of service users are also mentioned by respondents.

'Achique has given me a lot. Before, I did not feel like living, I wanted to kill myself. I could not find the way out. Many of us lost our families. Little by little you lose the will to live because if you can't get up and be happy, prepare breakfast and be with your family… When I came to Achique, it changed everything. They welcomed me as a family. You are not alone here. You always have a friend next to you. We are all in the same situation.' — SU3

Another achievement is simply pulling service users out of the immediate harm of their environment, which in turn can help service users think beyond their daily hustle. As one respondent explained, the success of such an intervention is in part due to its ability to help service users stand still and reflect. This 'pause' is a necessary starting point, from which service users can be helped in developing healthy strategies in dealing with substance use.

'For me, if someone watches the news while he's washing his clothes, and learns what happens in the world, that is harm reduction. That he has contact with a peer and laughs for ten minutes is harm reduction. And if you push me a little more, I would say that the success will change depending on each one's needs. From my point of view as a professional, a success is if the space is inhabited by people who, if they did not have the space, would be living in the street.' — P3

According to several respondents, succeeding to convey respect and tolerance to service users and convincing them that they are valued and capable of many things is very important, while at the same time being able to joke and laugh together.

'Before, I was in a deep hole, I looked like shit. I couldn't get out of the daily circle of getting up, eat something, use, get up, eat something, use, etc. etc. … Every day the same. Every single day. I could not escape. Achique helped me realise that I have to worry about myself. […] That is very good, because when you are in the gutter, the first thing that you

do is not love yourself. Seeing others look clean and tidy, you see that I can also be alright and look neat. I'm not a zombie!.' — SU6

Accomplishing such things for service users in a resource poor setting, practicing patience and tolerance to frustration is considered its own reward and a small success on a personal level.

'There must be a lot of love, patience and respect. That message must be conveyed often. Because often times their own enemies are themselves.' — P2

There is a tension, however, between making Achique as attractive and low-threshold possible, while also working towards social reintegration. That said, another measure of Achique's success is the fact that service users do manage to find their way back to Achique after having relapsed, which inevitably happens to its service users. Definitions of success are not always agreed upon.

'There are many people who come to Achique only to chill. For me, that's not right. For them, it is not good either. If they do not come with a mentality to move ahead, they do cannot prosper.'— SU1

Achique is not without its challenges. A major challenge of Achique has been that much of the work has been so dependent on a single person. When the founder, who had managed Achique alone, unexpectedly passed away in early 2018, taking over logistics (including bank cards, social media accounts, key documents etc.) without proper documentation proved complicated.

'Management should never depend on people, it has to depend on structures.' — P3

Related to this, Achique suffers from a lack of resources, including for basic things such as having enough cash at hand to buy food. In addition, the Achique office has no computer, internet connection or printer, meaning employees have to do all administrative work at home and in their own time. Achique does not have enough staff to accompany clients to referral services, even if they think this would be to the benefit of service users.

Other challenges relate to work integration of service users. One respondent mentioned that

in the rare instance when someone manages to secure a job, they lose access to harm reduction services, because operating hours overlap, and no services are available in the evenings or on weekends. Another challenge is that temporary jobs may provide PWUD with temporary stability, but without a more permanent solution, PWUD often find themselves forced to return to the same situation as before, which is discouraging and can lead to relapse. Also, since Achique is not open the whole day or during weekends, street-based PWUD do not always have a place to come to, meaning they spend more time in the streets.

A more structural challenge concerns the commitment of the supporting institutions. This uncertainty is challenging for the professionals working there, and extends to the professionals' job stability, although respondents acknowledge this instability has been part of Achique since the beginning. Achique's staff contracts are evaluated and prolonged every six months, so there's a high degree of insecurity and instability about the future and sustainability of the project. Further, since the professionals managing Achique are hired by a third party, they are not in charge of the centre and thus not finally responsible. At the same time, it's not immediately clear who's finally responsible.

'The problem of a centre like Achique that functions as a pilot is that one day it's here and it may be replicated in ten other sites. Or, tomorrow it's no longer there. That's the problem.' — P1

Finally, access to female users is also seen as insufficient. Although respondents acknowledge that men who smoke *pasta base* greatly outnumber women, the latter are much harder to reach. This is a concern because many female PWUD are mothers who need a place to leave their children during the day, which is not an option at Achique.

Moving forward
Respondents found it difficult to elaborate upon the future of Achique, since different stakeholders have different perspectives on the role of Achique in the national drug policy and 'treatment' landscape in Uruguay. Some governmental respondents mention plans to revise the role and function of Achique, aiming to redesign and export it to other sites,

potentially moving Achique to be closer to other services such as SACUDE.

'Achique is located in a place where the state has a lot of presence already (polyclinic, civic centre, sports centre, etc). The question is how to strengthen Achique so that it forms part of that existing network, and does not remain a satellite. That's a challenge.' — P3

Professionals working at Achique are hoping to develop more psychological modalities ensuring a more systematic approach towards social inclusion and reintegration for its service users. According to other stakeholders, Achique should focus on reaching more people on daily basis, arguing that the concept may not be sustainable if the DIC does not reach larger amounts of service users. One point of contention revolves around access: external professionals speculate that Achique may need to become more geared towards including the local community, and not just to PWUD. At the same time, other respondents acknowledge that working with the community is a challenge and might actually be counterproductive to attracting PWUD:

'We still try to include the community if we can, but it doesn't happen in a very structured way.' — P2

In sum, while most respondents agree about the benefits of Achique, there is no coherent or agreed upon strategy concerning the future of Achique, thereby impact its sustainability.

LESSONS LEARNED

1 Substance use is symptomatic of deeper psychosocial issues such as abuse, marginalisation, poverty, and violence. In order to help people reintegrate into society, transmitting basic values (such as respect, love and patience) and providing access to stable job opportunities are crucial.

2 Providing a safe, friendly and healthy environment is part of harm reduction, and a necessary starting point to take PWUD out of a chaotic, often violent and unstable situation. This space is necessary before one can start working on developing strategies to control or reduce substance use.

3 Transmitting, empowering and stimulating the self-esteem, self-worth and autonomy of service users are fundamental steps to enhance self-control around substance use.

5.6 Karisma's shabu outreach
An approach to outreach work in Indonesia

'Our project is really trying to reduce the harm for (meth) users, and to get them to access health services. We want users to be healthy and to know that, if they use drugs, they know the risks and how to protect themselves.' — P7

'Drugs should be used to make you happy and not dependent. I was able to draw that line, especially since knowing Karisma.' — SU1

Karisma's *shabu* outreach is the first harm reduction outreach work project focused on assisting PWUS in Indonesia, as well as on the South East Asian region. It reaches out to people who use methamphetamine in the capital city of Jakarta, on Java island. The outreach team and the peer educators provide PWUS with oral information and leaflets on meth, mental health issues, drug use and dependence, and the impacts of meth use on health. The team also distributes safer smoking kits. The project started in mid-2016 and has been taking onboard many lessons learned throughout the process. Meaningfully involving PWUS, including people with lived experience in the team, and investing in partnerships are some of the lessons the team has been applying in practice. Being the only project offering specialised assistance to PWUS, one of the main challenges is not being able to refer people who use meth to other services. Working with mental health problems linked to meth use is especially difficult. PWUS tend not to recognise their symptoms as mental health related, and services are not yet prepared to assist the population. Despite the challenges, PWUS assisted by the programme are very satisfied. They especially value the information received and the kits distributed. Moreover, service users feel the project offers them a place to be heard and to be able to use their experience to help other PWUS.

Image 21: Jakarta, Indonesia

Indonesia
Indonesia is a country in South-East Asia. It spreads over an area of almost two million square meters and more than 17 thousand islands. In 2016, the country counted 261 million inhabitants (World Bank 2018). The Indonesian territory is composed of 34 provinces. The country's population is highly concentrated in Java, the world's most populous island. Kalimantan and Papua are the least densely populated regions (KND 2018).

Regarding standards of living, 86% of the total population has access to a piped water source, and 60.6% has access to sanitation facilities at home. In 2014, the adult literacy rate was 92.8% (15 years and older) (HDR 2015). Indonesia is considered a low-middle income country by the World Bank, and it has been growing economically in the last 15 years. Despite the economic growth, inequality remains high: 10.6% percent of the Indonesian population lives below the national poverty line, and 70% of Indonesia's economy is concentrated in the island of Java only (World Bank 2018).

This case study's outreach work takes place in Jakarta, the country's capital and the largest city of Indonesia. Jakarta is located on the northwest coast of Java, and is the centre of economics, culture and politics in Indonesia. The city has a population of over ten million people and is a pluralistic and religiously diverse city, concentrating people from many other Indonesian islands. Around 83% of the population is Muslim, and other religions are Protestant (around 8%), Catholic or Buddhist (around 4% each) or Hindu (around 0.2%) (BPS 2017).

Substance use in Indonesia

Globally, it is estimated that around 34.2 million people have used an amphetamine-type substance in the past year, ranging between 13 million and 58 million, and its use seems to be on the increase (UNODC 2018b). In Asia, many countries report increases in methamphetamine use (UNODC 2018b; EMCDDA 2018b). . ATS are the dominant drugs of choice in Asia, with between 3.5 and 20.9 million people who use it (Pinkham and Stone 2015). The ATS market continues to expand, particularly in South-East Asia and China. Since 2009, methamphetamine prevalence has overtaken heroin prevalence across Asia (Thomson 2013).

According to UNODC estimates, Indonesia follows the regional trend with cannabis being the most widely used drug in the country, followed by methamphetamine, heroin, and ecstasy (UNODC 2016). Although its validity has been strongly criticised, the only national survey available about drug use presents similar results with methamphetamine, locally called *shabu,* as second most popular drug in the country (BNN 2015; Irwanto et al. 2015)**.** *Shabu,* is currently the most available drug on the market; heroin is difficult to get. In Indonesia *shabu*

is manufactured in small *kitchen-like* laboratories, with all its precursors legally available in the country (UNODC and Programme 2013). Jakarta, Denpasar, Batam, Medan and Makassar are the cities where *shabu* use is most prevalent (Nevendorff and Praptoraharjo 2015)**.**

A qualitative research conducted among 38 crystal meth users in Jakarta, Medan and Makassar in 2015 described three main types of relations people develop with meth use in these cities. Frequent users take meth daily and report to use it to gain more motivation and improve confidence in their work. They tend to use alone, and to acknowledge that crystal-meth causes problems in their lives. Practical users use meth for 3–4 times a week, based on their need to support their work. They tend to use in groups, and to be sex workers or blue-collar workers. They are more likely to substitute meth by another drug (such as alcohol) when meth is not available and more often claim to be willing to reduce or quit using meth in the future. Finally, casual or social users use meth three times a month or less. They decide to use or not according to their mood and money availability. Overall, meth users reported not to feel *addicted*, even when they use the drug daily (Nevendorff and Praptoraharjo 2015).

A quantitative research conducted between 2016 — 2017 in six major cities in Indonesia (West Jakarta, Denpasar, Batam, Makassar, Medan and Bandung) showed an HIV prevalence of 10% among meth users. Prevalence was much higher for those with previous injection experience (35%), when compared to PWUD who had never injected (3%). Similarly, HCV prevalence was 14% on average, and 62% for those with injection experience but 3% for PWUD who had never injected. Syphilis prevalence did not differ much between injecting and non-injecting groups, being around 1.3% for both. HBV prevalence was around 2% for both groups (Praptoraharjo et al. 2017).

As for the population of PWUS assisted by Karisma in Jakarta, many people currently using *shabu* are former heroin (locally known as *putaw*) users who can no longer find heroin. Many use *shabu* while also using prescribed methadone. Most people using crystal meth smoke the drug. In a few cases crystal meth is injected, mostly when people were used to injecting their heroin. Even rarer are the cases of

booty bumping (rectal administration). To smoke crystal meth, people normally use home-made bongs. Bongs are made from plastic cups or old bottles – such as glass bottles of typical Indonesian eucalyptus oil or plastic bottles - in which they make holes. People who use meth prefer small bottles, because it's easier to inhale the smoke. They generally prefer bongs over pipes as they feel the smoke is *softer* or less aggressive to inhale.
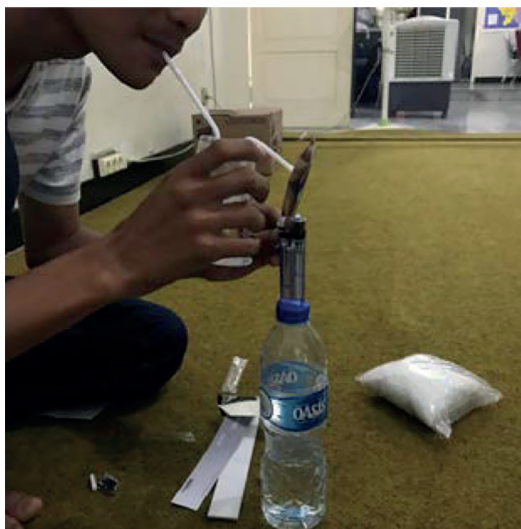

Image 22: Home-made plastic bong and foil

People assisted by Karisma tend to smoke crystal meth in groups. One of the reasons being the price. Crystal meth in Jakarta costs around 12 euro[14] (200.000 Rupiah) for 0.2 gram. By pooling money together as a group, PWUS can assure a high for everyone. The *new generation* of people who use meth tends to be young, around 14-28 years old. The *old generation* is around 35-40 years old, and they tend to be former heroin users. Most people using meth combine it with one or more substances to help calming down. Alcohol, cannabis and benzodiazepines are the most common choices, besides methadone for those who are in OST. The illegal use of prescribed drugs – mostly benzodiazepines – has been rising in Indonesia. Benzos are especially used to help induce sleep. Prescribed drugs are less expensive than *shabu* and users are not arrested

for possession in case they are caught by the police. Regarding alcohol, people usually use beer (purchased at supermarkets and convenience stores) or home-made alcohol (cheaper and usually sold under the table by street vendors). Cannabis is mostly used in its plant form, but synthetic cannabinoids (locally called *Gorilla*) are also sometimes used.

In Jakarta, many PWUS say they like the effects of *shabu,* as it enables them to be more active and productive, and they feel *lazy* when not using meth.

'When you use meth, you're more focused, more diligent. Like when you have a lot of kids and you want to take care of everything yourself and you don't have any help around the house. It makes you more productive.' — SU1

Drug policy and harm reduction

Indonesia has been fighting a War on Drugs, pushing for extreme punitive measures, such as the death penalty for drug trade. The National Narcotics Agency (BNN) regularly reaches the international media's attention for strict and backward statements around drug policies. For instance, in 2015, BNN declared treatment for PWUD as a waste of taxpayers' money (Arnaz 2015). Consequently, they intended to stop funding rehabilitation centres for PWUD (Siregar 2015). Law No. 35/2009 on Narcotics criminalises the use of substances, and makes reporting on drug use mandatory (BNN 2009). This not only criminalises PWUD, but also their family members who fail to report drug use or dependence.

Over the years, several violations of PWUD rights have been reported in Indonesia. Examples are: forced drug testing, detention, compulsory treatment, extortion and pressure on health facilities to disclose personal details and medical records of suspected drug users (Stoicescu 2015). As PWUD fear being reported for drug use and sent to compulsory treatment, they tend to be very cautious in accessing health services. Overall, the quality of compulsory treatment centres in Indonesia is questionable, as they lack an evidence based-approach (Larasati, Christian, and Misero 2017).

Despite the punitive rules, harm reduction is supported through two regulations: Social Welfare Ministry Regulation No. 2/2007, and Health Ministry Regulation no. 55/2015. Substitution therapy and

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14   €1 = 16.385 Indonesian Rupiah

sterile needles and syringes are specifically mentioned in the Health Ministry decree No. 55/2006 on Harm Reduction of Narcotics, Psychotropic and Addictive Substances (BNN 2011). Harm reduction services are available throughout the country, the majority still related to injection heroin use. In 2014, there were 232 Needle and Syringe Programme (NSP) sites and 85 Opiate Substitution Therapy (OST) sites, available in 63 different districts (UNAIDS, n.d.). NSP is offered by NGOs and primary health care services, and OST is carried out by public health services in primary health care clinics (called *Puskesmas*). By 2016, 11 Indonesian prisons were also offering OST.

The sustainability of harm reduction interventions, however, is still a challenge as most harm reduction activities are financed by international donors. And regarding the use of stimulants, little is available in public health. On the other hand, Indonesia has been at the frontline of an innovative approach on the ground, being the first South-East Asian nation to develop community-based harm reduction measures for crystal meth users. The case study described in this chapter offers an insight into the first outreach intervention in Indonesia and, as far as we know, the whole South-east Asia, which is specifically for people using meth. Aside from this one in Jakarta, another outreach project for meth users in Indonesia started being piloted this year in Makassar, financed by Mainline and run by the local NGO PKNM. The new pilot builds on Karisma's experience and recommendations from the evaluation of its activities.

Origins of Karisma's shabu outreach
Karitas Sani Madani Foundation (Karisma) – a community-based organisation- was established in 2001 by people whose lives have been affected by problematic drug use. The organisation focuses on drug addiction and problems associated with HIV/Aids. They offer a community-based recovery center, counselling for HIV/Aids and addiction, peer support groups and – since 2004 – outreach work. In 2004, the organisation got international funding to provide outreach work for PWID – who mainly used heroin – in Jakarta. In 2015, having run a solid NSP programme for over a decade, the organisation started noticing a drastic drop in their syringes distribution. If before they were distributing up to

20,000 needles a month, by 2015 the number was down to a couple of hundreds.

'We were asking ourselves what happened. It was just so hard to find new people that used heroin. At the same time, we saw the rise of the methamphetamine. And we really wanted to engage with and help people who use drugs.' – P6

Before 2015, national and international funding were covering NSP programmes only. When international funding to work with meth users was made available through Mainline in 2015, Karisma started developing the only project offering harm reduction for *shabu* users in Indonesia. The organisation worked closely with a local University, PPH Atma Jaya, to make a needs assessment. The university was responsible for an operational study to evaluate the pilot (Nevendorff and Praptoraharjo 2015). The outreach team started to work in July 2016. Two priority drug hotspots in Jakarta where chosen based on the needs assessment. The intervention targeted two aspects of harm associated with meth use: the health consequences associated with meth use and the specific harms caused by risky sexual behaviour. In the first six months, the programme assisted and documented 194 individuals, ranging from 16 to 61 years old; 75% of these were male. Along the way the staff has received trainings from Atma Jaya and Mainline on methamphetamine use and associated health risks, as well as on outreach work techniques. The trainings usually involve local PWUS as participants and experts.

In 2017, Karisma expanded its interventions to 8 drug hotspots, and reported to reach around 900 crystal meth users. The team's activities suffered from staff turnover that year, and overall, outreach workers found it difficult to build a trustworthy relationship with PWUS in just a few contacts. Because the team lacked people with experience of *shabu* use and thus had difficulties accessing users, more people with lived experience were added to the team. Peer educators were involved, and a female outreach worker was hired to improve the reach to female users, and particularly female sex workers. Atma Jaya researchers joined the field with Karisma and recorded how outreach was being done. By comparing the fieldwork with the needs assessment, they developed a local step-by-step guidebook on how to do outreach for *shabu* users. Karisma currently

bases its fieldwork on these guidelines (Karisma and Mainline 2017), although still looking for improvement and further focus on the specifics of stimulants.

Safer smoking kits also started being distributed in 2017. Due to uncommon items and the strict local regulations, it took some time for the team to arrange for suppliers.

Image 23: Safer smoking kits

In practice

Karisma's outreach team consists of five outreach workers, supported by peer educators. Each outreach worker is responsible for one of the districts of Jakarta – North, South, East, West and Central Jakarta. Outreach workers are also responsible to guide the peer educators and other volunteers in their area of action. Since the team got 2 new outreach workers and 4 peer educators in 2018, more experienced outreach workers mentor the new ones. Each district in Jakarta is divided in sub-districts, and in each sub-district, the responsible outreach worker and peers prioritise the *shabu* hot spots. These areas were mapped together with Atma- Jaya University through a needs assessment. While some areas – such as West Jakarta – have only 10 hot spots mapped, others – such as Central Jakarta – can go up to 17 hot spots. Outreach tries to go to each hot spot at least once a week and, on average, each outreach worker visits five spots a day. Outreach workers go in pairs to open a new area. Once they consider a field is ready to receive them, they go alone, since staff is limited.

Outreach workers and peers provide oral information and leaflets on meth, mental health issues, drug dependence, and the impacts of drug use on health and financial situation. The female outreach worker is responsible for approaching female users in all areas when needed, aside from being responsible for one district of Jakarta. She provides separate assistance for women when they express the wish of not mixing in groups with male service users.

'In my experience, women face higher risks in terms of meth use, as they are more vulnerable. They sell sex for money to buy meth more easily or become meth couriers and are taken advantage of; they are offered just a little bit of money or meth as a reward. When women are arrested they are also more prone to exploitation by police. They are more closed and secretive in terms of their drug use. Sometimes they use it only around their close friends, even their husbands or their families don't know about it.' — P4

The team arranges the schedule according to PWUD's movements. They observe which spots are crowded at which time and arrange their schedule accordingly. Fieldwork can be done during the day or in evening hours and is necessary also during weekends. The outreach approach depends on the PWUD' habits. For those who tend to gather to use meth, outreach prefers a group approach. Visiting the PWUD in their houses or the rooms where they use is also a possibility. In some spots there are rooms where people can both buy and use meth. Other rooms are just rented for use and strategically located close by the dealer spot. The outreach team's approach in these cases is to reach the person who rents a room and give him/her a package of paraphernalia (safer smoking kits and safer injection packs) and provide information and leaflets on harm reduction through this key person. People renting rooms get in touch with many users every day and can become a contact point spreading information on safer drug use. The staff advises people to use meth in closed spaces:

'I advise users to find a room to use. [...] You just want to prevent unwanted scenarios. When you're high and your environment is not supportive, it's not good for you. [...] People can also report you to the head of the neighbourhood if they see you while you're high. People feel uncomfortable seeing groups of users around and you might end up getting reported to the police.' — P1

A lot of new ideas for the outreach approach come from the team's weekly meetings. In these meetings they check the results of outreach strategies and try to find solutions for challenges. Peer educators and other volunteers are also invited, and sometimes take part in the meetings. Peer educators help outreach workers to reach out to users in their communities; They contact people they know in their neighbourhood to spread the information and paraphernalia. When more experienced, they can help the outreach team to open new spots, based on their contacts in the new areas. Peers work on a volunteer basis and receive mentoring from the outreach worker responsible for their district. At least bi-monthly, peer educators meet at Karisma with the outreach team to exchange their outreach experiences and develop a plan for the following months. Service users are also invited to join. A major challenge in getting peers to attend the meetings is that the organisation does not have enough funds to compensate everyone for their participation, and transport and food costs can act as an impediment.

Peer educators get training in public speaking, outreach techniques, and information on harm reduction for meth and prevention of infectious diseases.

'I attended a training and I found out a lot of information I didn't know before. So, I thought: Oh this is quite useful, why not do something good?' – P2

Around 17 PWUD were actively involved as peer educator or other voluntary support in the project at the time of the research. Peers said to share their knowledge of *shabu* harm reduction with their friends and contacts, offering themselves as a role model on which friends can rely.

'A lot of users are my friends and people I have interacted with in the past. I know that they are not living healthily... And that's where I come in to give them some direction. [...] I tell them, for example, to look at how I was in the past and to compare to how I am now. I've experienced everything they have first-hand. They can relate to the experiences that I've had.' – P1

Both the outreach team and the peers distribute safer smoking kits consisting of lighter, foil, straws and IEC material (image 23). Printed messages on the foil and the lighter – 'eat, drink and sleep' – function

as a reminder. Karisma's desire for the future is to provide more, like a complete bong, which would ensure that PWUD don't inhale toxic materials from the home-made bongs. While distributing the kits they also give PWUD harm reduction information.

Image 24: Glass bong with glass pipe

Users have a strong preference for using meth in a bong and use straws attached to their home-made bong. The younger generation of users do not use foil (as in image 22), but rather prefer a glass pipe (*cangklong*) (as in image 24) or use a glass pipet (from ear medicine, for instance). Sometimes pipets are preferred for glass pipes for being less obviously linked to meth use, and therefore, less risky when stopped by the police.

Even though nowadays people can easily get into trouble with glass pipes or bongs, the team would like to distribute glass pipes, as it would be easier for people not to share if everyone has their personal pipe. The team believes this is a matter of time and advocacy. Although, in practice, it might prove to be challenging to bring change in the culture of sharing and the collective feeling that goes along with it among some PWUD groups.

'Similarly, in the past, while doing outreach work for heroin users, people could get arrested for carrying needles and syringes. It took a lot of advocacy

efforts to change this. So, at first, it's possible that carrying bongs is dangerous, but it might change as people – including the police – will be more informed and understand about its importance.' — p5

In 2018, the outreach team reaches around 60 individual users a day. Although this in principle represents an increase from previous years, the team still has a lot of repeated contacts with the same users. Each fieldworker has a target: every day they need to meet at least 10 meth users, and at least one of them new to the programme, as they want to increase the programme's reach. These targets cause tension between the reach of the project (and lowering the costs per capita) and the quality of assistance and time needed to bond with PWUD.

'It doesn't happen instantly, getting someone to open up. Sometimes you just come and they (PWUS) immediately leave (out of suspicion). So to really get that person involved and really want to listen to you, that takes time.' — P1

Outreach workers register the number of people assisted and the type of assistance given – paraphernalia or leaflets distributed, referrals, themes discussed. They also keep a contextual map – including social and economic conditions, local habits, organisation of the community, and the patterns of drug consumption – of each spot to have a better idea of the needs of the population. For every user,

they try to map drug using patterns and the financial resources used to support their use. This gives an opening to talk about sex work or work as trafficking courier, and to direct interventions towards specific needs. The numbers of people reached by peer outreach workers are not being registered yet.

Staff and finances
In 2018, the programme has a yearly budget of €45.000.

Around 70% of the total budget goes to staff payment. That represents €27,000 of salary and €4,500 on social security and employment charges. The rest of the budget (€18,000) largely covers for expenses with direct activities such as: FGDs with PWUS, needs assessments and mapping, reimbursement of transport and meals for PWUS partaking activities, networking meetings, local transport costs for outreach workers, IEC material, and safer smoking kits. Besides, the project's budget contributes with €2,500 to the overall operating and administrative costs of Karisma.

Teaming up
One of the biggest challenges of Karisma's *shabu* outreach relates to the integration of services. This is the first project to provide harm reduction for methamphetamine in the country, and staff reports that even the available PWUD services are generally not prepared to assist meth users.

Table 9: Staff involved

Function	Quantity	Part-time / full-time	Paid/Volunteer
Project coordinator	1	Part time	Paid
Manager	1	Part time	Paid
Field coordinator	1	Full time	Paid
Outreach worker	5	Full time	Paid
Finance officer	1	Part time	Paid
Data entry	1	Part time	Paid
Peer outreach worker	4	Part time	Volunteer
Other volunteer peers	13	Part time	Volunteer
Janitor	1	Part time	Paid

Table 10: Funders

International donor (Mainline)	90%
Self-funded (staff contribution or through other services offered by the NGO)	10%

'Right now, for the meth users, Karisma is the single fighter.' — P7

'Even though there are some services for people who use drugs, they don't necessarily target meth users. For example, we have around 18 to 20 primary health clinics that provide services for people using drugs. If we try to bring a meth user, they go like: "okay, what do I do with this?"' — P6

Some of the partnerships Karisma had established for previous projects working with PWID are running well for PWUS as well. PWUS can be referred to TB and HVI testing, counselling and treatment. Heroin users can get access to methadone or suboxone OST. And PWID have NSP available. Rehab is widely available, although as mentioned before, drug treatment lacks an evidence base. Karisma also runs their own rehab centre and refers those meth users who are willing to quit to this centre. These are usually people who are on the brink of getting arrested or having serious problems with the family.

Regarding human rights and legal protection, the project collaborates with the Indonesian Drug Users Network (PKNI) and a Community Legal Aid Institute (LBHM). Karisma refers PWUD who get caught with a small amount of meth but are still prosecuted as dealers. The national Narcotics Law states that possession of less than a gram (of meth) is considered for personal use. According to staff and service users, however, when somebody gets arrested with a small quantity of drugs (i.e. one package), s/he is often charged with Article 114, which is supposed to be for drug dealers, while users are supposed to be charged by Article 127. When users get caught, outreach workers bring their family members to PKNI to get informed about the situation. At PKNI or LBHM, they will be asked about the background of the user: whether they've undergone rehab, or they have accepted any health services. They look for proof that the person is indeed a user.

'In Indonesia, drug-related cases are used by the police to get money. The police would file a charge against you, for instance with Article 114, but then they would make an offer: "do you want to be charged with Article 127 instead of 114? If so, you need to pay me with a price of a car". Yeah... Indonesia. That's very expensive.' — P5

Apart from these partnerships, the project faces difficulties in virtually all other partnership areas. In the care sector, the main challenge is assuring mental health care for meth users.

'Every time they want to get counselling, or if they want to talk about their feelings or problems, it's difficult for them to find people. If they approach health facilities, normally the health workers do not have enough information for them. [...] most counselling services are not well-equipped for meth users – only for heroin users. They don't have the knowledge in terms of counselling for shabu.' — P3

To address this challenge, the team planned nine informative events for meth users regarding mental health at different health facilities during 2018. The idea of the meetings was to invite local doctors to talk about mental health and the types of services offered by the centres. Outreach workers briefed the doctors beforehand on the appropriate language to use with the population. At the time of the research, two of these meetings had happened. Between 15-20 users were present in each session. The meetings were only partially successful from staff's perspective. Doctors did inform participants on the services available but did not talk about the procedures and processes of accessing mental health services, as costs and registration. Also, from service users' perspective, the presentation was not very attractive or comprehensive. Adjustments would be made for next meetings.

Another problem with accessing mental health services relates to costs and lack of documents. Services can be free of charge if people have a national health insurance. On average, however, PWUD do not have health insurance because they do not have the necessary documents for it (ID, Family Card, and residence register). Arranging for documents can be free of charge, but the process requires a lot of effort. According to staff, social workers are hard to find in Jakarta: they are few and mostly inside the ministries instead of close to the field. Many users either don't know where to search for social support or are not willing to put in the effort it takes. Outreach workers have limited time to accompany users.

Another great and long-lasting challenge is the relationship with the police.

'The narcotics police are difficult to reach out to. We even invited them to our events, but they never showed up. They are present in each area. However, they are separate from other [police] divisions. They don't want to be known. These narcotics police mostly work undercover.' – P3

Virtually all PWUD in this case study said to have or know someone who has been arrested because of drug use, and all are afraid of being reported by/ to the police. Undercover police infiltrates in user groups to find dealers and report users to rehab. This plays an important role in PWUD paranoia and cautious feelings about allowing new comers to their drug using groups.

'You get paranoid that everyone can be somebody who report you to the police.' – SU7

Users' fear of getting reported to the narcotics police also brings challenges for outreach workers and peer educators to promote meetings and events with users, as people tend to be suspicious.

'Let's say there's a meeting for meth users. Meth users will think, "oh no". They will think there's someone there to catch you. Like, "Oh, maybe there will be police coming."' – SU1

Successes and challenges

The staff is careful when talking about the programme's achievements so far:

'We are not that successful yet, it is still a process [...] But I have seen some changes in the users we work with. They didn't have any information (about meth) and now they know some. And they changed the way they use meth. They know the risk.' – P7

From the staff's perspective, one of the main achievements so far was to increase the information users have about meth and to trigger PWUS to think about ways of reducing the harms associated with it.

'When I first reached out to them, they said "oh is there information about meth? I had no idea!" It's completely new for them. People have been using it for a while, but information on meth had never been there before.' – P4

According to staff, PWUS now tend to engage less in risky behaviours and to care more about their health. They, for instance, are more careful when carrying meth (to protect themselves from police approach), and increasingly have their own bongs.

Service users also claim to have increased their knowledge about meth and how to reduce the harms of its use. They also appreciate the information about various harms and diseases such as TB, HIV and Hepatitis. The harm reduction strategies users mostly said to be applying were: eating before doing drugs and not forgetting to drink and sleep. Users also said to always carry condoms and more frequently using them when having sex. A previous research among meth users in Jakarta had shown that meth use was associated with less self-control and an increased likelihood of engaging in unsafe sexual behaviour (Nevendorff and Praptoraharjo 2015). It is thus certainly a success, that PWUS referred to be more consistent in using condoms.

Despite knowing the risks, however, PWUS admitted having difficulties changing some behaviours. Not sharing bongs was considered especially difficult. Using groups tend to buy the drug collectively and sharing is part of a ritual not only related to drug use but also to food, spaces, etc. For the ones who could refuse sharing, they reflected that in their cultural context, not sharing involved developing sensitivity skills to be able to say no without offending others. Some service users claimed to have reduced, stopped, or achieved a better control over their meth use since partaking Karisma's outreach activities.

'From my personal experience, after I started to get involved with Karisma, I noticed that I started using less. [...] suddenly I'm surrounded by people who support me instead of staying away from me. Automatically I got distracted from using drugs.' – SU6

Several service users said the support offered by Karisma made a great difference in their lives. It helped them to increase self-care and self-esteem and got them interested in looking beyond drug use alone. Sharing their stories with the outreach team helped them to find solutions to underlying problems causing problematic use. These conversations

and meetings also helped them to get more social and less isolated.

'We feel this office like our home. Our stories are heard, and we feel supported because of it.' — SU8

'They care about you and your health. If you are sick, they help you to find a health service. Even your own relatives don't care that much, but Karisma does. You can call them anytime of the day and they will drop by.' — SU2

Image 25: Lighter for distribution

Service users also appreciated the referrals to health centres and rehab and were very satisfied with the legal support offered by Karisma's partners.

Staff expressed some pride in noticing that some PWUS are starting to take care of themselves and spreading the knowledge and the harm reduction practices they have developed among their peers.

'I feel proud when clients become more independent, and when clients are eager to invite and assist their friends in accessing health services at Puskesmas. I feel proud when they really show progress at a personal level, especially in terms of independence.' — P5

Despite these preliminary successes, the challenges are still many, and mostly related to the contextual circumstances in terms of service availability and drug regulations. As mentioned before, partnerships remain complicated and a major difficulty relates to addressing mental health issues. According to staff, the average person in Indonesia does not understand what mental health services entail. Most people associate mental health with insanity and do not understand or talk about depression, anxiety, or stress in these terms. Similarly, most of Karisma's service users do not recognise the concept of mental health or themselves as having mental health problems, despite the fact that virtually all of them mentioned becoming paranoid and being *very emotional* after having used meth.

'If we offer mental health information or services, they would refuse and say: "I'm not crazy".' — P4

To cope with this challenge, the outreach team is investing in networking with care facilities and organising meetings with mental health professionals, as explained in the teaming up section. This is generating some positive results as it helps people to recognise mental health problems:

'They attended meetings about mental health and realised that meth users can also have mental health issues. They realised that what they experienced was in fact related to mental health. That was new for them.' — P4

Besides that, the outreach team is organising FGDs with users to get more insight on how they may approach mental health.

'We discussed their meth use in the past year, in terms of what they experienced; if they experienced paranoia, hallucinations, etc. And we asked them about how they overcame those issues. Most of them just ignored these issues.' — P3

These are all still first steps, according to the team, and much more work is needed to be able to properly address mental health issues.

Another challenge the team faces relates to the drug regulations in place. The team struggles with increasing the reach of the programme in terms of numbers of users assisted. They feel they need to visit PWUS very often to be able to develop a trustworthy relationship, given the strict law enforcement approach in place.

'Right now, shabu use is booming, but it is also becoming more known among the police. The police want to stop people from using shabu, so they might stop a stranger and ask: "do you use meth?" [as outreach work would do]. People will never say "yes". They will say: "what are you doing?! Are you a policeman?!" There is always suspicion.' — P7

Finally, the team still faces the challenge of switching the outreach work approach and mentality from assisting PWID to assisting PWUS. At least three of the five outreach workers had previous experiences of doing harm reduction work with heroin users. Overall, *shabu* users have less knowledge over the drug and its use, their groups are less open to newcomers (and outreach), and they are less inclined to recognise harms caused by their drug use.

'Heroin users tended to be more knowledgeable in terms of the type of information we're giving them. Meth users tend to be less knowledgeable about this. It's all still new.' — P3

'Still for us the heroin user it's much easier. I don't know whether it is because of our history, our experience, but they also have this awareness about themselves that, "I need help, I have a problem and I need help." In contrast, the meth user doesn't. [they think that] The heroin user is the one with problems. "I don't get withdrawal, I don't experience withdrawal symptoms, I can still go to work and still okay" [they think]. That's the main challenge, to increase awareness about the health risks associated to meth use.' — P6

Moving forward

The staff has many ideas to improve the programme. On a broad level, they aim at advocating for funding for harm reduction in Indonesia. Most funding comes from international donors, and since Indonesia is considered a middle-income country, international funding is under threat. The big challenge is to assure funding from the national government. NGOs in Indonesia cannot get sustainable funding because of restrictions in regulations. Currently, an NGO can be only hired three times for short periods. If the national government was to fund harm reduction in the future, a solution would have to be found. Karisma remains hopeful that the government will be willing to find such solutions, since they have seen an increasing support for harm reduction from the national government in the last decades.

One of the steps the team is taking to make national government funding more feasible is to build a partnership with another Indonesian harm reduction NGO (*Rumah Chemara*) to write National Guidelines on how to do harm reduction for methamphetamines. Besides creating contextualized guidance for local NGOs, this could also facilitate funding for projects and networking. Most of the health clinics in Jakarta only provide services if there is a national guideline. When a national guideline is available, it is also possible to budget for activities.

Regarding mental health assistance, the team is organising a partnership with the national Ministry of Health and the Provincial Health Department to discuss counselling issues for PWUS. The country has national guidelines for harm reduction, which do not include ATS yet, and Karsima would like to include specific issues for PWUS in these guidelines. Besides Karisma and the Ministry of Health, representatives of the university Atma Jaya and the 18 primary health care facilities which have Compulsory Reporting Institutions[15] are being invited, along with counsellors for addiction, to an initial meeting to kickstart the partnership still in 2018.

At the ground level, staff would like to further promote PWUS' self-organisation and independence.

'The next objective is to create a community of ATS users so that they can get to know each other better and create a bigger network in different areas. For example, they could help spread and exchange information and support each other, so that they will be more independent and self-sufficient.' — P5

The work of peer educators is seen as fundamental to reach this goal, and the outreach team would like to have more funding to support peers who want to engage with the programme.

In terms of paraphernalia, both the staff and the users would like a bong to be part of the safer smoking kit. Besides that, staff would also like to try

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15 It is at the Compulsory Reporting Institutions that an assessment is made to determine which service the people who were reported as drug users need.

distributing a silicone mouth piece so to reduce the risks of sharing.

Moreover, both service users and the outreach team would like to have a drop-in where users could hang around, ideally coupled with a safe space to use drugs.

'In this kind of safe space, you know the people and you know that they won't report you. Unlike at home, sometimes your neighbour could also be the one who reports you to the police, or they would knock at the door. We prefer a place where we can chill and relax.' — SU7

Finally, the team is planning to improve the programme's reach. Outreach is working on the balance between the quality of contacts (which takes time) and the number of people assisted. Since a lot of repeated contacts have already taken place, gradually including new PWUS seems feasible. Besides, the recent inclusion of peer outreach workers will be a helpful asset in spreading the programme's wings.

LESSONS LEARNED

1. The most important when promoting harm reduction to a 'new' population is to know the area, the population of users and their characteristics, so to build an approach. Building a trustworthy relationship is fundamental for that. Having people with lived experience in the team, as well as both female and male outreach workers and peers, helps connecting with a variety of PWUS.

2. Pioneering a project with a population not assisted before requires extra effort in networking, sensitising partners, and building services integration. Pioneering in a context of strict drug regulations and law enforcement also requires extra efforts and time in building trust with PWUS.

3. Being a pioneer in a context of strict regulations may require a compromise between the reach of the project (and lowering the costs per capita) and the quality of assistance and time needed to bond with PWUS in this initial phase.

5.7 Princehof, Ripperdastraat and Schurmannstraat

An approach to Drug Consumption Rooms in the Netherlands

'Drug consumption rooms are professionally supervised healthcare facilities where drug users can consume drugs in safer conditions. They seek to attract hard-to-reach populations of users, especially marginalised groups and those who use on the streets or in other risky and unhygienic conditions. One of their primary goals is to reduce morbidity and mortality by providing a safe environment for more hygienic use and by training clients in safer use. At the same time, they seek to reduce drug use in public and improve public amenity in areas surrounding urban drug markets. A further aim is to promote access to social, health and drug treatment facilities.' — (EMCDDA 2018c, 2)

In contrast to Drug Consumption Rooms (DCR) abroad – mainly servicing PWID – the Dutch facilities primarily target PWUD who smoke their substances. Typically, Dutch DCRs target long-term problematic users of freebase cocaine and heroin (and methadone), with only small numbers of people who inject or snort their substances. Moreover, there is very limited use of other substances at these services.

In this chapter drug consumption rooms in the Netherlands will be discussed, through the study of three exemplary locations: Princehof in Amsterdam and Ripperdastraat in Enschede, two very different DCRs, but both strongly integrated with other PWUD services, and the Schurmannstraat in Rotterdam, an intensive supported housing facility with a drug consumption room in the living room for their 20 residents.

Image 26: Amsterdam, Enschede & Rotterdam, The Netherlands

The Netherlands
The Netherlands is a coastal country in Western Europe. According to the United Nations database, the country had a population of 17 million people in 2017 (United Nations 2018). The Netherlands is part

of the European Union, where it is the sixth largest economy. The country has a stable economy with relatively low unemployment rates. Nevertheless, 590,000 households in the Netherlands (8.2% of the population) lived below the poverty line in 2016. 224,000 of these households have lived below the poverty line for four years or more.

The Netherlands is a small country with merely 41,542 km2 of surface area. It has 12 provinces. Together, the four biggest cities and their surrounding areas, form the megalopolis The Randstad. Two DCRs included in this case study – Schurmannstraat and Princehof – are located in cities in the Randstad. The third location is situated in Enschede, a city in the east of the Netherlands, close to the German border.

Substance use in the Netherlands

In the Netherlands, the National Drug Monitor presents a yearly report on developments in drug use, policy, treatment and crime. According to the monitor of 2017, Cannabis has been for a long time and remains to be the most used drug (aside from alcohol) in the country. In 2016, an estimate of 880,000 adults (6.6% of the population) have used cannabis in the past year, and 4.1% of the adult population used Cannabis in the past month. More than a quarter of those who have used cannabis the past month use it (almost) daily (van Laar et al. 2018). Note that Cannabis has a rather unique status in the Netherlands; it has been categorised as *soft drugs*, meaning in practice that although it is still officially illegal it is sold over the counter in *coffeeshops,* in many Dutch municipalities.

In 2016, around 230,000 adults (1.7% of the population) had used cocaine, 390,000 (2.9% of the population) ecstasy, and 180,000 adults (1.4% of the population) had used amphetamines. In comparison to other European countries there is high prevalence of amphetamine and ecstasy use. Moreover, the use of stimulants has been on the increase between 2014 and 2016 (van Laar et al. 2018). There is no data on the prevalence of use of methamphetamine in the Netherlands. So far, its use only takes place in a small niche of MSM who engage in chemsex. There are some signs that its use seems to be on the increase in the gay scene. Moreover, a relatively high rate of injectors has been reported among these men (Knoops et al. 2015b). This drug scene with its use of crystal meth, injection and frequent combined drug use faces many high drug risks, in addition to high risk sexual contacts.

The total number of registered drug related deaths has increased between 2014 and 2016. There is no clear understanding of this increase, but possible explanations are changes in the registration of deaths, an increased use of medicinal opiates, more toxicologic research or the aging of PWUD (van Laar et al. 2018).

Although the prevalence of individuals in treatment for amphetamines has been on the increase in recent years, the number of people in treatment for ecstasy or amphetamines is relatively small (less than 500 and 2,500 individuals respectively), in 2015. More individuals sought help for their problematic cocaine use (around 13,500 individuals) in 2015, but these numbers have been in decline since 2006. Of those seeking help for cocaine use, merely 1% injected their drug. Almost half of those in treatment were there for freebase cocaine, and a little over half for cocaine HCl, which they snorted. Cocaine HCl is relatively popular among youth and young adults who go out, while freebase cocaine is common among opiate addicts who often formed part of the (homeless) street scenes in the Netherlands in the 1980s and 1990s. While combined use of heroin (or methadone) with freebase cocaine is common, there are also plenty of individuals in this scene that use freebase cocaine without using opiates (van Laar et al. 2018).

This last group is the main target group of DCRs in the Netherlands. Professionals and service users of the three locations, including the sheltered housing facility with DCR, all named freebase cocaine as the primary drug of choice among its service users. Heroin use, or rather subscribed methadone, is also very common among these PWUD. Furthermore, the service users can be characterised as an older PWUD group. The majority is 40 years or older with a high prevalence of mental health problems (including PTSD, depression, AD(H)D and schizophrenia), physical health problems (particularly lung infections and diseases and liver infections), and social problems (such as financial debts). While many have been homeless in the past the vast majority of DCR visitors has some sort of housing at present. Moreover, most make use of integrated

care services, including social work, debt management, and psychological support. New and younger PWUD do access the DCRs as well, but it is mainly for this aging group of PWUD that the DCRs offer a safe space and access to related services.

As for the Antes' sheltered housing facility at the Schurmannstraat an additional characterisation of the PWUD residents is that they are not capable of living independently. The residents are all males between 40 and 70 years of age, and all struggle with social and (mental)health problems. The five residents that took part in the Focus Group Discussion, all use freebase cocaine, and three of them also use methadone and heroin. They said that all residents of the Schurmannstraat use freebase cocaine.
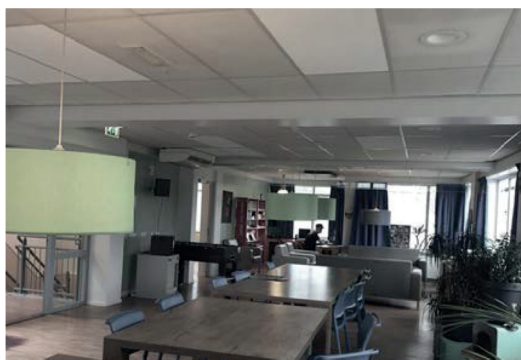
Image 27: The living room at the Schurmannstraat

Drug policy and harm reduction

In the Netherlands, harm reduction receives political support and is incorporated in the official national drug policy. The Ministry of Health, Welfare and Sports (VWS) is primarily responsible for the coordination of the drug policy, in collaboration with the Ministry of Security and Justice. The Netherlands actively supports harm reduction abroad via its Ministry of Foreign Affairs. Pursuing a pragmatic approach, a drug free society is not seen as realistic. VWS builds its drug policy on four main pillars, namely: information, prevention, treatment and harm reduction.

This policy results in the availability of a wide range of harm reduction services throughout the Netherlands, primarily funded either by national or local government agencies. These services include: NSP, OST, peer-to-peer drug education at parties, distribution of drug use paraphernalia, anonymous drug checking, outreach work, online information and helpline, drop-in centres and of course drug consumption rooms, to name just a few.

Origins of the three drug consumption rooms

The first DCR in the Netherlands was founded in 1995. Since then DCRs have continued to open, with a peak of new DCRs in 2004-2005 (Havinga and van der Poel 2011). Early 2018, according to a yet to be published Dutch DCR inventory, the Netherlands counted 26 DCRs in 21 different cities. Amsterdam and Rotterdam are the only two cities with more than one DCR facility in the city, three and four respectively. This inventory does not include the supported/sheltered housing facilities with a drug consumption room for its residents, such as the Schurmannstraat in this chapter. In the past decade, such PWUD friendly housing facilities have increased in numbers all throughout the Netherlands. As most people who use drugs problematically in the Netherlands are no longer homeless, the number of DCRs have decreased. It is safe to say that the number of sheltered/supported housing facilities has increased, even though exact numbers of such facilities aren't available.

De Regenboog Groep's DCR Princehof opened in 1999. Originally the building was a housing and treatment facility of the Amsterdam addiction treatment services, but De Regenboog Groep took over.

'26 years ago, I worked for the needle exchange service in Amsterdam. There was no DCR then, but people kept asking for a place where they could use. Around the year 2000, if I remember correctly, we opened the DCR. Around this same period the needle exchange got a permanent location, together with a women's shelter. All these services later merged into one service location, around 2003.' — P9
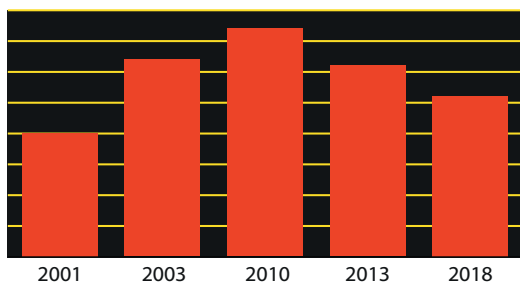
Graph 1: DCRs in The Netherlands

The DCR Ripperdastraat in Enschede opened in 2006 as an integrated service location. Its running has always been supported by the municipality, primarily because it contributes to nuisance reduction of PWUD.

Most former homeless users of heroin and freebase cocaine are now housed and largely over the age of forty, if not older. This is also the case at the sheltered housing at the Schurmannstraat, where the youngest of the twenty male residents is in his early forties, and many of them are pensioners. Sheltered and supported housing services for older PWUD in the Netherlands deal with substance use in different ways, some prohibit it, some allow residents to use in their rooms, and others have an in-house DCR. The latter stimulates open dialogue and allows for supervised use.

Moreover, social services in the Netherlands have – over the years – become increasingly focused on social reintegration and recovery. In line with this development, DCRs have increasingly become part of integrated services with social workers paying more attention to individuals' capacities and ability to work and (re)integrate, in comparison to the early DCR years. Thus, DCR service users usually have access to social workers, treatment services, medical and psychological care as well as work or more low-threshold day activities through the DCR. Many DCRs offer their own low-threshold work activities in exchange for small reimbursements, and in Groningen (North of the Netherlands) there is even a low-threshold work integration centre with their own DCR for its participants.

'Nowadays, we (Schurmannstraat) work a lot more with recovery and participation. This place is no longer seen as an end-station. The challenge is the extent to which this is possible; can someone really become self-sufficient? Once they go and live independently there is no longer any supervision. Some of our residents really need the acute and 24-hour care that we offer at this location.' — P3

In practice
All DCRs offer a safe space for people to use their drugs in a safer and more hygienic environment, under the supervision of qualified staff. Moreover, they provide for an access point to other health and social services. As mentioned before, the Netherlands has *public* DCRs and *private* DCRs, being part of a work integration centre of housing facility.

The *public* DCRs each have their own access criteria and intake procedures. For instance, at both the Ripperdastraat and Princehof the services users have to be dependent of substances, minimum 25 years of age, and registered citizens of the municipality. They also have differing criteria. For instance, Princehof requires people to be homeless at the time of application or known for being a public disturbance, they must have an ID and sign a contract. At Ripperdastraat this is not required, but here it is a strict requirement that service users must bring their own drugs into the facility; this is checked at the entrance.

'We (i.e. social workers) do the intake procedure for two of De Regenboog Groep's DCRs. With some room for individual manoeuvring I check them on the location's criteria. You must have been using for at least five years. Most people smoke freebase cocaine. There is no injection room, and while in theory the place is for all drugs, but in practice its really only for people who use freebase cocaine, heroin and methadone. We try to link people to professional support as well. I want to talk to them regularly, even if only once in two weeks. There has to be contact with someone who can help them further if necessary.' — P10

A little more than half of the DCR intakes is accepted. In principle service users get access for one year, and each year their access gets revised. Sometimes, if necessary, the social workers can also

grant access to the DCR for a shorter period. For instance, when access to the DCR can help bridge a brief homeless period. Illegal migrants cannot get access to the Princehof, nor can non-entitled[16] migrants. However, the latter group can get access to another De Regenboog Groep DCR, which offers social services specifically for these migrants in Amsterdam.

At the Schurmannstraat the service users can also only get in through a professional referral. As the case manager nurses work in the DCR, outreach work, medication distribution (including methadone) on location and the heroin maintenance programme it is relatively easy to continuously adjust services to the PWUD's current needs. Whenever someone is ready someone can move towards outreach work at home, while keeping the same case manager. Other benefits of such an integrated approach were also mentioned.

'Recently one of our clients, who smokes heroin in the heroin maintenance programme, suddenly also came to smoke heroin -up to three times a day- in the DCR. This raised a red flag. Because we work on all the shifts we notice these things as a team. We then had a conversation with her about it, and consulted the doctor about it: 'is she getting the right dose?' She told us she wasn't feeling so well, slept badly, but didn't want to talk about it. [...] This is picked up by her case manager.' — P7

At both locations service users can get access to the following services:
· Warm meals, coffee/tea and sandwiches.
· Clean needles or other drug use paraphernalia, such as screens for the pipe and foil.
· Condoms (at Princehof these are only distributed to the women).
· Recreational activities, such as painting or making music.
· Social and judicial support.
· Work projects on location and upon referral.
· Access to showers and clean clothes.
· Administrative support and possibility to use phone.

16 Non-entitled migrants are migrants who have the right to reside in the country, but do not have right to care or social services in the Netherlands. These migrants often come from Eastern-European countries.

· Referrals to mental and physical healthcare, treatment facilities or housing support.

Some of these services are offered out of the drop-in centre, which in both cases is at the same location. At the Ripperdastraat service users can also see a doctor, get tests or treatment for infectious diseases, Naloxone is available in case of an opiate overdose, and they even have extensive birth control for women.

'For two years we offer pregnancy tests and we really stimulate injectable birth control. If they want to have children we stimulate getting clean first, and of course no one is obligated to get the injections, but if they want it they can get it for free, we keep track of the intervals and repeat the injection every three months. About half of our female clients make use of this service, I believe.' — P6

Image 28: The grounds and drop-in at Ripperdastraat

At the Schurmannstraat the DCR is a room next to a living room for all twenty residents. If a resident wants to make use of the DCR they have to request this at the reception and they can take a couple of residential friends if they want. The DCR is opened from 6AM till 11PM, people can take their time to use there, and there is camera surveillance.

'It helps us keep an overview. We can see who uses when, and if someone suddenly uses more often we can talk about it. As a mentor I have that conversation with someone. I'll ask how much they use and if they drink as well, so we can take that into account. The residents know they can't use in their rooms, and that they don't have to use secretly.' — P4

There are always two housing support staff members on location, and every resident has one of them as their mentor and one as co-mentor for all practical and social support. They can pretty much get help with everything they need. For more medical and treatment related support an Antes care practitioner visits at least once a week. This care practitioner is responsible for supervising the treatment plan and general case management.

At all three DCRs, people can get help with payment of bills or debts, arranging an ID, looking for independent housing or getting access to detox treatment. Also, a very important role of the staff on location is to just listen to the PWUD, hear their stories, connect with them and give them moral support. At the sheltered housing facility, the housing support staff also assists in household chores.

In practice, however, a service user at Princehof and a service user at Ripperdastraat both mention that their main reason for going to the DCR is the social contact. For instance, when SU1 comes to the DCR he drinks some coffee, plays table tennis, uses the computer and talks to others, including two friends he made at the DCR.

'The DCR to me is like a café, a place to meet people and converse.' — SU1

All three locations provide for the opportunity to do low-threshold work or alternative day activities. Participants receive small reimbursements, usually a couple of euros for half a day's work, and do different kinds of work. At the Ripperdastraat and Princehof the PWUD do tasks such as to help with cleaning, cutting up the foil or cooking, or in Ripperdastraat's case even work at the in-house bike repair shop. At the sheltered housing facility, the residents are required to do a structured work activity at least two half days a week. This is mostly to bring some structure in people's lives, but it also gives the PWUD a little extra money and distracts them from alternatively only being fixated on drug use. For most work activities the residents can be picked up as a group by a little bus and will be brought home at the end of the day. In house they have a rotating schedule for all the responsibilities, such as cleaning, dosing the dishes, grocery shopping and cooking. All is done with support of the staff.

In a group discussion with five residents of the Schurmannstraat they shared that participation involves more than low-threshold work and chores.

'Every Monday evening, we have our residential meetings. And you have to eat at home at least four days a week. [...] At the residential meetings we can suggest things such as the purchase of a foosball table or changing the times we cook dinner. All input is taken into account. They really respond to it, and always report back on our input. Also, everyone has to help in the house, and they note if you have done your chores.' — SU4 and SU5

Also, at the other two facilities, the possibility for service users to provide input to change has been formalised through regular service user meetings with staff. However, both staff and PWUD in this case study mention that service users have limited interest for these regular meetings. Partially because people can also just give feedback on the go whenever they talk to one of the staff members.

Staff and finances

The Schurmannstraat (Antes) is coordinated by one full-time regional manager and a full-time location manager. Furthermore, there are several full-time and part-time housing support staff. There are three different shifts during which there are always two staff members, and during the day there is also an intern present. They help with day to day practicalities.

'They can basically get help in all kinds of ways: financial, questions about financial letters, help with cleaning -although they hardly ask for that- [...] We are here 24/7, but they have to ask for help during the day. [...] to protect their circadian rhythm.' — P5

For more specialised support a care practitioner – who is a nurse by profession – comes to visit each resident individually at least once a week.

At the Princehof (De Regenboog Groep), The DCR is in the same building as the drop-in centre. At each given time there are 6 people working in the building, but only one person is working in the DCR. The project is run by a part-time manager, and three project coordinators (one full time and two part time). There are two porters, one general DCR staff member, 3 part time volunteers, several social study

interns, and two part-time social workers who work at this location and other locations.

At Ripperdastraat (Tactus) the DCR services is run by nurses. There is one manager, two senior nurses and 16 regular nurses. The nurses are responsible for case management of the service users at the DCR, medication distribution, the heroin maintenance programme and the outreach service. They work on a rotating schedule in each of these services and are all responsible for a certain number of clients.

'I work (as a nurse) 36 hours a week and I am responsible for 18 service users. 10 of these visit the DCR, the other 8 I visit during outreach work at their homes. The outreach service users usually have day activities and a network outside of the drug user scene. That's generally not the case for those who visit the DCR.' — P7

There is a guard at the gate of the integrated services, which also includes work activities, a drop-in centre, computer room, a band rehearsal room, and an alcohol consumption room for alcoholics who take part in the street sweeping programme. When necessary the nurses refer to a part-time doctor, who is also part of the team.

All three DCRs are funded primarily, if not fully, by the local government. In recent years, municipalities in the Netherlands have gotten increased responsibility over local health and social policies.

Teaming up

All three DCR locations are part of a larger organisation with diverse services on offer. They all work together both with the services within their organisation as well as with external organisation, for instance through referral.

As mentioned previously, partnerships exist with low-threshold work opportunities. All three DCRs have these on offer within their own organisation, but to offer people the best support and opportunities they can also get referred to work at other organisation. Or, of course, a real salaried job is always an option too. This, however, has proven to be a little too challenging for many DCR visitors.

At the sheltered housing, the previously mentioned care practitioner takes on the role as case manager. They are part of a Flexible Assertive Community Treatment (FACT) team from Antes, through which the residents have their own psychiatrist and addiction specialist doctor. The housing support staff helps residents get registered with the social services, or professional support to pay their debts. In case of mental health emergencies, the crisis service can be called. Besides, the housing support staff maintains close relationships with the GPs of the residents. Through the FACT-team residents can get into any kind of rehabilitation treatment or other kinds of mental- or physical health care. Princehof primarily works together with the municipal health services, Jellinek, Kruispost and Doctors of the world, and the MDHG. Through the municipal health services,

Table 11: Staff involved

Antes	De Regenboog Groep	Tactus
Regional manager	Regional manager	Manager
Location manager	Location manager	Doctor
Housing support staff	Project coordinators	Nurses
Care practitioner	General DCR staff	Guard
Interns	Porters	
	Volunteers	
	Interns	
	Social workers	

Table 12: DCR funding

Antes	De Regenboog Groep	Tactus
Local government (80%)	Local government (majority)	Local government (100%)
National government (20%)	Donations (minority)	

the DCR service users can get methadone and any kind of testing or treatment related to sexual health. The municipal health services are furthermore responsible for heroin maintenance treatment. Those who receive heroine through this trajectory have to smoke their heroin at the municipal health services but can still come to the DCR to use free-base cocaine. Jellinek is the main drug treatment facility in Amsterdam. Service users can be referred to these services for addiction treatment -such as detoxification or outreach rehabilitation-, mental health support and for dentist services. Kruispost and Doctors of the World enable healthcare services for people who are uninsured, such as those who are in the country illegally or homeless people who have not paid for their insurance. So even though illegal migrants cannot access the DCR, the Princehof staff can see them at the drop-in and refer them to basic healthcare support. The MDHG is the drug user union and offers low threshold practical and emotional support to marginalised PWUD. There is also close contact with involved outreach workers, and occasional contact with service users' GPs.

At the Ripperdastraat, some of the external services of the Princehof – i.e. medication distribution, outreach services and heroin maintenance – are offered internally. Moreover, they are the main drug treatment service in Eindhoven and can thus refer to detox or rehabilitation services within their own organisation. Tactus also has four hostels for PWUD, with whom the DCR works together closely.

'They see different behaviour from us. Sometimes it can be helpful to discuss things with a contact person there. Usually I will ask consent from the service user in advance. We can read each other's client reports.' — P7

However, they too work together with a whole network of external partners. Just like Princehof they keep good relations with the municipal health services, GPs, and other medical services (such as hospitals). They can also have contact with the pharmacy in case they have questions about the service user's medicine use. They are part of a professional network which a.o. includes sheltered housing, a welfare organisation and local social services.

Lastly, all three locations invest in maintaining good relationships with the police and neighbourhood. An ongoing dialogue with both police and neighbours stimulates community acceptance. For example, neighbours can get invited to an open day of the facility and will be heard (and responded to) when they have a complaint about (one of) the service users. With the police agreements are made, such as the prevention of public drug use in the neighbourhood, and the police will be contacted when the misbehavior of a service user cannot be dealt with at the location.

Successes and challenges

When discussing the successes of Drug Consumption Rooms, the service users in this case study name several. In the focus group at the sheltered housing there was general consensus that the most important success of the place is the safety it offers them in their lives. In the FGD the residents express their appreciation of structured rules, and how they really see the house and its DCR as their own space. They would love to make the room even more *gezellig* (i.e. cosy) – for instance with paintings that one of them makes – and appreciate the camera monitoring so staff can come to their assistance if something goes wrong. The major annoyance (and the reason why some decide to use in their rooms), according to the FGD participants, is that everyone can see you have dope when you go into the DCR. *'And seeing dope triggers craving'*. Since you are allowed to bring a small group with you if you want the others will hussle you to tag along. *'But we have solved this quite well among each other'*. One of the FGD participants even maintains a rotating scheme; his best friend always gets priority, but the others get turns.

A Princehof service user, describes the main successes of the DCR as follows:

'The primary way in which the DCR has contributed to my quality of life is through food. There is almost always healthy and plenty of food available here. [...] Socially the place also is of great value. They are a soundboard for my ideas, but they can also be a mirror for me. They can check my health and tell me when I don't seem to be doing so well. I cannot always do this myself. All in all, the DCR offers me food, a soundboard, and a health check.' — SU1

Moreover, DCRs have been running in the Netherlands since 1995, with relatively strong social acceptance. The three case studies in this chapter have all managed to keep reasonably good relations with neighbours, police and local politicians. Not only have they proven to be sustainable over the years, they have also most certainly contributed to the stabilisation of problematic drug users in the Netherlands, and the disappearance of a street user scene. Most of the DCR service users, whether public or part of a sheltered housing, are part of an older PWUD group with stabilised drug use patterns and very little social disturbance.

The general aging of service users presents DCRs with new challenges. For instance, over the years a number of public DCRs have closed, and sheltered housing locations where people can use have opened in return. However, keeping sight of the drug use of the residents and/or keeping them from using in their rooms can be difficult. Furthermore, with hardly any PWUD causing disturbance on the streets public support can wane, as its raison d'être is less apparent to third parties. Lastly, as the PWUD grow older, they face more and more old-age problems, notably: social isolation and health problems. DCR locations have picked this up in various ways, usually having several referral options for health care, and – aside from the social function of the location itself – staff offers support in social (re) integration. However, some topics can be difficult to address, and the fact that many service users are so used to their marginalised PWUD life styles can make it difficult to motivate them at times.

'I think we need to pay more attention to their sexual needs. [...] Many residents and staff members find it difficult to talk about this. Sometimes when residents joke about it this can be offensive, but how do we pick this up and talk about it with someone. How do you have that conversation? It is a part of life, but it remains to be a big taboo.' — P4

'Some people have been coming her for years. I don't necessarily agree with that. People shouldn't make use of a service for their whole lives, they shouldn't get stuck. We're not going to change that anymore for our older clients, but with our new clients we do push development. [...] Most of our older service users don't really have specific personal goals, apart from finding a house. Some see the DCR as

a sort of café; for several the DCR is a home away from home. New service users must think about their goals, and work to stabilise their lives. Few manage to do so.' — P10

'If they want basic education or professional help at the DCR they can always get it, but most people don't want it. Most people are 40 years or older and have been using for a long time. They know the basics by now, and therapy is too confronting for them. Maybe the DCR sometimes offers these, but there is no demand for it. They don't want it, they are afraid of it.' — SU1

Moving forward
Overall, the DCRs are somewhat confident about the sustainability of their programmes, and probably rightfully so. At present, DCRs are not a politically sensitive topic in the Netherlands. Over the years the DCRs in the Netherlands have generally developed to strong integrated services that may take various forms, depending on the local context. Some social developments that have affected DCR services are expected to continue in the future, namely: the need for adequate response to an aging PWUD population, the preference for outreach work over clinical settings, integrated services and strong care and service networks, and recovery work and participation as a core value.

'I think we should increase our focus for the small steps that they can still make. I know it's possible.' — P2

'I'd like us to work more with the recovery principles, to focus more on their self-reliance.' — P3

'I'd like to expand our outreach services. Even though these service users don't come to the DCR we can help them better in their own homes. It's easier to see how someone is really doing. Think of little things, such as plants that have suddenly died or a very dirty toilet. At the DCR people often pretend like everything is fine.' — P6

Moreover, several professionals mention their desire to improve existing working relations with other services, for example mental health services or hospitals, who often lack know how on how to deal with PWUD when they are under influence.

In contrast to the professionals, the service users are not so much focused on moving forward but tend to make suggestions for the expansion of DCR services. The two service users of the public DCRs both think opening hours should be expanded. At Princehof people can stay in the DCR for unlimited time and it is opened seven days a week, but at the Ripperdastraat there are only six places in the DCR so everyone gets 30 minutes per session, and it is closed on Sundays. They also have reduced opening hours on Saturday.

'Even a mere 15 minutes extra would be nice. Now we even have to leave when no one is waiting to get in, but smoking is a social thing. […] And six places is too little. The alcoholics have more room [red. there is an alcohol user room next door, for alcoholics participating in the clean-up team] and they can sit there all day. The difference is too big. Their room is also opened in the weekends.' — SU2

The FGD participants at Schurmann would like to have more fun activities on offer, but confess that this used to be offered, but has been cancelled for the time being because a lot of people didn't show up. This is similar to the experiences at the Princehof. One service user explains that this will probably remain to be the case as long as the use of cocaine is not facilitated during the activities, as people at the DCR are constantly busy with hustling and using drugs. This PWUD as well as the FGD participants would all like to have access to their drugs in a legal manner (either through legalisation or medicinal distribution). Moreover, they would all like the DCR to be more *gezellig*.

6 Conclusion

In recent years, several regions in the world have witnessed an increase in the use of stimulants. These developments further underscore the need for effective strategies to cope with the harms related to stimulants use. Much of the evidence and harm reduction services available focus predominantly on people who inject (opioids). Overall, people who use stimulants (PWUS), and especially those who do not inject, have more limited access to specific services available for them, and often access to harm reduction services in general. Many PWUS experience different health-related harms and problems, do not identify with (problematic) opioid use, and often belong to different (social) networks of PWUD. Thus, they may perceive harm reduction services as irrelevant or inaccessible to them. This happens despite the fact that PWUS, and especially those coming from difficult socio-economic conditions, are often marginalised, and face a diverse range of social and health problems. Much like the recommended set of interventions to prevent, treat and care HIV among PWID, no single intervention will address the many issues experienced by PWUS across the world. Any comprehensive package of interventions for people who use stimulants will need to consider the effects of specific substances, different routes of administration, groups of users, types of interventions and contextual variations such as social, cultural, political, legislative and religious aspects.

This report presents the first comprehensive overview on evidence and practices for harm reduction for people who use stimulants. The study offers a thorough literature review on different stimulants and people who use them with an in-depth exploration of good harm reduction practices for people who use stimulants in different parts of the world. In it, we focused predominantly on interventions for people who smoke methamphetamine and freebase cocaine. While we initially aimed at addressing other amphetamine-type substances, cathinones and cocaine hydrochloride, as well as other non-injection routes of administration, most of the available harm reduction literature and interventions turned out to address smoked meth and crack.

The main contributions of the present study are twofold. First, it provides a literature review on the evidence of what harm reduction interventions are effective for PWUS. The selected literature was clustered into 12 harm reduction interventions for which we found evidence of effectiveness in reducing the harms of stimulant drugs use. These strategies are: safer smoking kits, prevention of sexual risks, female focused interventions, drug consumption rooms, self-regulation strategies, housing first, substitution, outreach and peer-based interventions, drop-in centres, drug checking, online interventions, and therapeutic interventions.

Second, this report documents seven case studies of good harm reduction practices for PWUS in different cultural contexts. These seven cases reflect a selection of a diverse range of: types of harm reduction strategies, types of stimulants, social and cultural contexts, gender aspects, types

of drug policy in place, level of integration in health-care system, linkages with other (harm reduction) services, available resources, and geographical regions. We have described an approach to housing first for people who use crack in Brazil, an online intervention for people who practice chemsex in Spain, contemplation groups for people who use methamphetamine in South Africa, distribution of safer smoking kits for people who use crack and/or methamphetamine in Canada, a drop-in centre for people who use *pasta base* in Uruguay, drug consumption rooms for people who smoke crack in the Netherlands, and outreach work for people who use methamphetamine in Indonesia.

6.1 Lessons from the literature and the good practice cases

Many studies offer proof for the efficacy of harm reduction strategies for stimulants. The 12 strategies described in this report are the ones we found to have most evidence available. Some strategies have a solid evidence-base. This is the case for safer smoking kits, drug consumption rooms, housing first, outreach and peer-based interventions, and thera-peutic interventions. For other strategies, some evi-dence of effectiveness is available for people who use other substances, but lack evidence for PWUS. This is the case for drop-in centres, female focused interventions, and prevention of sexual risks. Others still, such as for plant-based substitution, drug checking, self-regulation and online interventions, may show positive initial evidence, but need proper assessment through further research. Finally, pharmacological substitution has a vast amount of literature available, but its effects remain mixed and inconclusive, although there are some promising results. Some of these interventions, including plant-based substitution, drug consumption rooms, and drug checking, are exposed to legal challenges and critical political debates, complicating their formalization as harm reduction solutions.

The seven good practice cases described in this report brought many lessons and, for every case, we have presented the main ones at the end of each chapter. Here we summarise some of them. In many contexts, although a stimulant may be people's pri-mary drug of choice, poly-use is common. PWUS try to optimize their high, or manage adverse effects of their stimulant use, by using alcohol, GHB, opioids, cannabis or prescription depressants. It is important to acknowledge the risks of poly substance use, and wherever possible, promote healthier alternatives.

In most, if not all of the interventions we studied, both PWUS and the professionals working with them stressed the importance of low-threshold services. The foremost elements are to provide a warm, safe, friendly and welcoming environment to reach people who often have suffered from social exclusion, violence, economic vulnerability and unstable family situations. Not only is this important to attract PWUS to the services, it also creates room for people to reflect about their lives, before they can work on self-care strategies such as reducing the harms of stimulants use or controlling substance use. Loneliness and a lack of social structure can also be addressed by providing a welcoming environment that transmits a sense of family and belonging, something that many service users lack in a chaotic, street-based lifestyle.

This does not mean that service users should be pampered: empowerment of service users is also a recurrent theme, and promoting autonomy, stimulat-ing their self-esteem, and encouraging service users to employ self-regulation strategies is something that many participants found helpful. This includes setting rules and limits in the services. Providing structure and the option of participating in meaning-ful activities counters feelings of worthlessness that people can experience, and can give them a sense of purpose. This, however, must be complemented by more structural harm reduction strategies to help PWUS to further reintegrate into society. Such strategies can be providing people with stable housing and helping them to conquer sources of income, albeit this can be difficult in contexts where the economy is vulnerable, and unemployment is high. Substance use can be symptomatic of deeper psychosocial, economical or cultural issues, includ-ing marginalisation, homelessness, isolation, job-lessness, poverty, and violence. In that sense, harm reduction interventions which focus on improving PWUD' environment may also influence substance use.

Regardless of the context we studied, creating a family-like atmosphere and a sense of belonging were very important to PWUS. The feeling of being accepted and belonging, helped people learn that

they can hold each other accountable and it created solidarity with others, increasing feelings of self-worth and stimulating self-care.

Although not all interventions meaningfully involved PWUS in all levels of service delivery and management, no one questioned the importance of involving peers. Especially in outreach, the involvement of peers is indispensable. This also relates to understanding the population, their language and modes of using the substances, as well as the context in which the use occurs. This is especially important when trying to reach new populations. Establishing a good and trustworthy relationship with PWUS is fundamental and requires a welcoming and non-judgmental attitude. Working with peers who come from the same social group is also key in connecting with (new) groups of PWUS, irrespective of the social or cultural context, or the specific substances they use. A non-judgmental approach should also be present in any information presented to PWUS. Providing factual, non-sensational information on substance use and associated risks, in a language that is familiar to the target group, is paramount for an effective harm reduction approach.

Another lesson learned from this study was that when reaching out to PWUS it can be very helpful to have a concrete benefit to offer besides information. This can be as basic as water, a hot drink or meal, or harm reduction materials such as safer smoking kits. Providing materials was perceived by participants as facilitating the initiation as well as the maintenance of contact with PWUS.

The integration and/or linkage of (health and social) services also proved to be important. While we initially set out to describe one main (type of) intervention in each study, in practice no case described provided any service in isolation. When prompted to suggest what elements could help improve their service, many participants thought that either a better integration of services (a one-stop-shop being the ideal model) or better linkages between complementary services (that are friendly to the needs of the target group) would improve the offered interventions. Integrated services can better accommodate the different needs of individual PWUS. In selecting services to partner with, programs need to first assess PWUD needs to then combine it with public resources locally available.

Finally, integrating care services may be more efficient and cost-effective, but may also prove more challenging in resource-poor areas or in cases where harm reduction projects are stand-alone pioneers.

Establishing a novel harm reduction intervention for a population that has not received services before is a challenge. It requires extra effort in establishing connections with other organisations, but also with the target group, particularly when working in repressive contexts. Pioneering interventions can also mean having to compromise between expanding the reach of a program and assuring the quality of assistance needed to build a trustworthy relationship with PWUS.

Mental health assistance is of special concern for people who use stimulants. It can be particularly challenging for harm reduction staff to handle mental health problems such as psychosis, depression or unpredictable and aggressive behaviour. Especially in settings where mental health care is underdeveloped, building referral systems to specialized care can be difficult. In any case, basic training in mental health aspects can help frontline staff to respond adequately to basic symptoms.

Some substitute substances may be helpful in mitigating craving and other adverse effects of stimulants use. Evidence from small-scale studies as well as empirical findings in Uruguay suggest that cannabis may be effective in some cases, but more research is needed in this area as cannabis use can have adverse effects.

Lastly, evidence for the efficacy and/or cost-effectiveness of harm reduction services for PWUS is scarce. Even the most successful long-running interventions have only anecdotal or small-scale evidence. Introducing basic monitoring and evaluation tools can help measure the impact in a more effective way. Indicators can focus on a range of aspects: from impact on increased self-control, frequency and amount of substance use to the impact on quality of life, life circumstances and family relations. More research into the effectiveness of interventions is needed, including research that would include economic modelling.

6.2 Do we need specific harm reduction for stimulants?

To a large degree, harm reduction for stimulants follows the same fundamental principles as harm reduction for other drugs. Good harm reduction services start by providing low-threshold services, meeting people where they are, providing information and materials based on people's needs, providing outreach and mobile services for those unwilling or unable to visit fixed sites, involving peers as staff members, and ensuring people have access to other relevant services. It is also important to recognise that the use of any substance does not take place in a vacuum, but rather in a specific social, cultural, economic, legal, policy, and political environment. Maintaining control over one's use, and thus managing both individual and social harms, depends to a great extent on social mechanisms, including rituals, social controls and other social rules. Environmental risks negatively impact the lives of people who use drugs. One can think about unemployment, poverty, homelessness, violence, unstable housing, incarceration, substances adulterants, (lack of) availability of high quality harm reduction services, drug legislation, law enforcement practices, and public policies. This is no different for people who use stimulants. PWUS may develop substance use related problems and harms as a response to challenging psychological, social, economic and cultural environments. Problematic stimulant use is, in many cases, a social problem in need of structural solutions. It requires a re-centring of the focus away from the substance per se. Even those interventions that do not focus on the substance, such as housing first and drop-in centres, for instance, are able to decrease stimulant use and promote more controlled consumption. In addition to drug treatment and harm reduction services, people need programmes that promote safety, warmth and stability.

That said, there are several elements specific to stimulant use – and the sleep deprivation resulting from prolonged use of stimulants – particularly (acute) mental health, such as paranoia, hallucinations and anxiety. Addressing these problems can be challenging, particularly in resource-poor areas, in settings where mental health issues are still strongly stigmatised, and where proper mental health care is not available. Some specific strategies to reduce the physical risks of stimulant use are related to stimulating safer sex, a healthy sleeping pattern and healthy diets including prevention of dehydration, as well as taking care of general and dental hygiene.

6.3 Recommendations for follow up research and interventions

The scope of this study had a limited scope in terms of time-frame and number of good practice cases it could include. Here, we recommend future follow-ups to increase the availability of evidence-based information and practices on harm reduction for PWUS.

Further literature review could include additional evidence on mindfulness and how it could be used to improve the mental health and quality of life of PWUS. Mindfulness seems to be effective in promoting self-control, and more research into this topic could provide insight into a cost-effective method to support PWUS. Another important area of investigation relates to the inclusion of men in parenting and gender focused harm reduction programmes for PWUS. Gender-based research and activities targeting parenting of PWUD tend to focus exclusively on women, excluding men from reflecting on their role and responsibilities. Further research could also lead to concrete recommendations for better ways of including reflections on masculinity, gender relations and fatherhood in harm reduction programs assisting men and women using stimulants or other drugs. Finally, there is limited understanding of how mental health can be improved among people who use stimulants in resource poor settings. Further research could help gather which mental health services for PWUS are effective and available and provide a set of recommendations for organisations working in settings with less developed mental health facilities.

New studies on good practice cases should also consider documenting interventions that were not included in this report. Drug checking is one such example. Another theme worth investigating are ways of addressing the adverse effects of sleep deprivation following multiple day use of stimulant use, including chill-out zones in urban areas or at music festivals. Very little is known about effective harm reduction interventions for people who use cathinones, and a good practice description of such programmes could include other novel stimulants as well. We also recommend documenting evidence

of either pharmaceutical or mild plant-based stimulants as a substitute for illicit stimulants.

We also recommend developing practical guidelines based on the available evidence to facilitate the set up of high quality harm reduction services for PWUS. Such guidelines should provide guidance on how to train harm reduction and health care staff on recognising and adequately responding to mental health problems of PWUS.

Finally, given the low availability of funding for harm reduction for (non-injection) stimulant use, it could be worth creating a specific fund for harm reduction for PWUS. Such a fund could stimulate harm reduction to move from a narrow focus on HIV to one addressing broader health rights and quality of life for PWUS. In the long run, of course, governments play a key role in the implementation of harm reduction services for all people who use drugs – regardless of their substance of choice. Some governments have already set an example in this, for instance through initiatives to foster the evidence base or through the support of harm reduction services for PWUS.

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