

# SPEED LIMITS

EXECUTIVE SUMMARY

## HARM REDUCTION FOR PEOPLE WHO USE STIMULANTS



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**MAINline**



# Executive summary

## Glossary

ATS	Amphetamine Type Stimulants
CBT	Cognitive Behavioural Therapy
CRA	Community Reinforcement Approach
DCR	Drug Consumption Room
DIC	Drop-In Centre
FGD	Focus Group Discussion
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
MSM	Men who have Sex with Men
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
PWUS	People who use stimulants
STI	Sexually Transmitted Infection
TB	Tuberculosis

## Introduction

In recent years and in different parts of the world, the use of stimulants has grown. This development underscores the need for effective strategies to mitigate the harms related to stimulants use. Most harm reduction services focus predominantly on people who inject opioids, and little evidence exists on harm reduction for people who use stimulants (PWUS). Overall, PWUS, and especially those who do not inject, have limited access to harm reduction and other services. Many PWUS experience different health-related harms and problems, do not identify with (problematic) opioid use, and often belong to different (social) networks of people who use drugs. Thus, they may perceive harm reduction services as irrelevant or inaccessible to them. This happens even though PWUS, and especially those in difficult socio-economic contexts, 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 people who inject drugs (PWID), no single intervention will address the many issues experienced by PWUS across the world. Any comprehensive package of interventions for PWUS 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 an overview on harm reduction interventions for problematic stimulant use. In it, we focus predominantly on interventions for people who smoke methamphetamine and freebase cocaine. While we initially aimed at addressing other amphetamine-type substances (ATS), 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 worldwide literature review of harm reduction interventions for PWUS. Second, it documents, describes and analyses seven cases of good harm reduction practices for PWUS in different world regions.

## Methodology

The literature review focuses on the evidence for the effectiveness of harm reduction strategies for PWUS. It includes publications between 1998 and 2018 in the scientific and scholarly field as well as grey literature (such as local and international reports). Local, national, and international publications in English, Spanish and Portuguese, both qualitative and quantitative research, were included. A collection of over 1500 publications was narrowed down, the remaining selected literature was clustered into 12 distinct harm reduction strategies for which sufficient evidence was found.

The selection of good practice cases was guided by both the literature review findings and initial consultations with over 50 harm reduction projects and experts in more than 30 countries. Important selection criteria were: available evidence on effectiveness; sustainability; cost-effectiveness; the potential for replicability; being recognised as a good practice in the region among professionals and people who use drugs, and a willingness to cooperate in the study. The final selection represents a diverse range of harm reduction strategies, stimulants used, gender aspects, types of drug policy in place, and geographical regions. These seven cases represent examples of how to put solid (stimulant) harm reduction interventions into practice, considering the realities of different regions and target groups in need of harm reduction strategies' development.

All seven case studies followed a similar structure of investigation. We analysed the programme's local documents, carried out a structured questionnaire collecting programme data, interviewed at least eight professionals involved with the harm reduction service, and interviewed at least two service users individually. For the cases in Brazil, South-Africa, the Netherlands, Indonesia and Uruguay, interviews were done face-to-face, and additional data was collected through observations and focus group discussions (FGD) with four to ten service users. In Canada and Spain, interviews were done over Skype and telephone, and additional data was collected via e-mail.

## Literature review

The literature review summarises the available evidence for the effectiveness of 12 types of interventions aimed at reducing the harms of stimulant 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, internet-based interventions, and therapeutic interventions.



### Safer Smoking Kits

For people who smoke stimulant drugs, *safer smoking kits* have been found to prevent injuries to the mouth and lungs caused by the use of self-made pipes. While most

evidence refers to safer smoking kits for crack, some studies also evaluate kits for methamphetamine. In the kits, filters help reduce damage to throat and lungs, pipes and (rubber) mouthpieces may reduce cuts and burns to the lips, as well as reduce damage to the lungs and toxicity. Kits must be adapted to peoples' preferences and needs, as this increases the acceptance of safer smoking equipment and prevents PWUS from continuing to use self-made pipes. In some cases, when PWUS communities resist switching to more sterile instruments, an alternative may be teaching methods that can reduce the harm of using self-made pipes.



### Prevention of Sexual Risks

*Sexual health risks* and stimulant use are strongly connected. Prevention of sexual risks should include free access to condoms and lubricant, information about

sexually transmitted infections (STI) and HIV, low-threshold access to HIV and STI testing and treatment, contraception and pregnancy testing and counselling, talking about sexual risks, and developing plans to improve self-control over risky behaviours. Addressing sexual and physical violence, transactional and commercial sex, and abusive relationships are also important. Chemsex is defined as intentionally combining sex and the use of certain drugs, especially among men who have sex with men (MSM). This phenomenon has become more visible

quite recently. Chemsex frequently occurs in private settings and combines both substance-specific and sex-specific risks. An integrated approach to deal with the harms involved with this practice, such as offering Chemsex drug treatment services within MSM-friendly sexual health clinics or services is suggested. Relatively little evidence exists, as new interventions to address this complex phenomenon are being pioneered. These include outreach work with Chemsex-specific information, education and communication materials and safer smoking, injection or snorting kits, as well as informative websites and peer (support) groups.



### Female Focused Interventions

*Women who use drugs* are exposed to additional harms in comparison to men. Specific strategies for females fall in three categories: access to care, pregnancy and

parenting, and sexual and reproductive health and rights. Providing specific services for all women who use drugs is recommended. For pregnant and parenting women these should include obstetric, gynaecological and STI care, mental health, personal welfare, and childcare and family support. For those engaged in sex work, evening opening hours and mobile outreach help increase access to services. Other recommendations include removing 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. Interventions also need to include partners of female users. For pregnant women who use stimulants, some guidelines mention improving nutrition, decreasing tobacco smoking, decreasing alcohol and other drug use, promoting dental health and encouraging physical activity, encouraging early and continuing prenatal care, and reducing any enforced actions in services, such as requiring abstinence to receive care.



### Drug Consumption Rooms

*Drug consumption rooms* (DCR) are professionally supervised health-care facilities where people can use (stimulant) drugs in safer and more hygienic conditions. Although

DCRs traditionally target injectors, they increasingly focus on people who smoke or sniff their drugs. DCRs reduce morbidity and mortality of PWUD by

providing a safe, non-rushed environment, access to sterile equipment (such as safer smoking kits), and trainings in safer use techniques. They also increase access to hard-to-reach PWUD, reduce public drug use, and can promote access to social, health and drugs treatment facilities. This helps to prevent mental health problems and the exacerbation of social problems. Furthermore, studies show that DCRs reduce the transmission of infectious diseases, contribute to overdose prevention, and enhance safer drug use practices. They may also facilitate transitioning away from injecting to less harmful routes of administration.



### Self-regulation Strategies

*Self-regulation* approaches focus on empowering PWUD in developing skills and competencies to gain more control over their substance use. Self-regulation

can be trained, and a high degree of self-regulation is associated with lower drug use problems. Methods may include setting rules for the amount or frequency of use, only using when feeling well, never using alone, never sharing and only using one's own materials. Circulation of self-regulation mechanisms is ideally done with the close involvement of peers. Mindfulness-based interventions can enhance self-regulation and reduce cocaine and methamphetamine use. These interventions are characterised by systematically paying attention to the present moment with a non-judgmental and accepting attitude. This can help PWUS to cope with distressing events or unpleasant emotions by changing unhelpful thought patterns, preventing people from escaping unwanted emotions in substance use, and increasing self-control. Mindfulness based interventions are also effective in treating stress, anxiety, and depression; all aspects of mental health that are associated with problematic (stimulant) drug use and relapse.



### Housing First

*Housing first* seeks to move people into permanent housing as quickly as possible, in contrast to treatment first, which demands people to go through a series of stages,

such as becoming abstinent, before they are ready for housing. This is relevant because stimulant use has been associated with poverty, unemployment,

incarceration, homelessness and unstable housing. An adequate supply of stable housing can be considered a harm reduction intervention in itself. Additionally, housing first interventions are related to decreases in substance use, higher quality of life, higher levels of autonomy, reduced stress and an increase in personal safety. For PWUS, a stable housing situation provides the basis for stability, daily routines, privacy, and less stigmatisation, and leads to healthier eating and sleeping habits.



### Substitution

*Substitution* is replacing one's stimulant of choice with a substance that has comparable effects, typically with a longer duration, milder and fewer side effects. The

replacement substance should decrease the use of the primary substance, and/or reduce its adverse effects. Regarding plant-based substitutes some small-scale evidence exists for the use of cannabis in diminishing anxiety, aggression and paranoia in people who use freebase cocaine. Cannabis can also reduce craving, stimulate appetite and promote sleep. Results, however, are still inconclusive and further research on this is needed. Evidence for the use of pharmaceutical substitutes is inconclusive. Some evidence suggests that dex-amphetamine may be effective for people who use (crack) cocaine, and that methylphenidate (Ritalin) and bupropion may work for people who use amphetamine. The wakefulness-promoting agent modafinil might be effective as well, but the evidence is inconclusive.



### Outreach and Peer-based Interventions

*Outreach work* helps to reach those PWUD who do not come to harm reduction services themselves. This increases people's access to care

and can encourage bonding between PWUS and other service providers. Outreach done by peers is particularly effective for safer drug use education and distribution of paraphernalia. Peer outreach work with PWUS reduces the frequency of stimulant use and sexual risk behaviour, as well as risks of contracting an infectious disease such as HIV, HCV, and TB. It also increases acceptance of safer smoking kits distribution among PWUS. Outreach work can encourage PWUS to either avoid injecting or to switch to smoking or snorting by distributing

paraphernalia, such as safer smoking and snorting kits or gel capsules during outreach.



### Drop-in Centres

*Drop-in centres (DICs)* function as places where people who use stimulants and other drugs can meet others, find a listening ear, access (health) information and, for some, attain a degree of distance from potentially problematic home or street environments. DICs should be located near the PWUD community and involve members of the PWUD community to run the programme, offer services, and be involved in the decision-making process on which services to offer, staff needed and servicing hours. DICs contribute to the improvement of wellbeing, (mental) health, social engagement, and access to sexual and reproductive health services of PWUD. DICs also help reduce drug use and the exchange of sex for drugs.



### Drug Checking

*Drug checking* is a harm reduction measure developed for people who use (stimulant) drugs in night-life settings. It comprises a variety of technologies used to check and monitor dosage, contents, and presence of potentially hazardous adulterants in the samples that are handed in by PWUD. This information can be used to issue specific health warnings, and to address specific groups of users. Drug checking is a useful way to reach and educate hard-to-reach young people who use drugs, or novel psychoactive stimulants. Drug checking can also incentivise people to not consume a particular sample, e.g. if it is found to contain an unwanted substance or a harmful adulterant. These technologies have varying levels of accuracy and reliability; and range from simply demonstrating the absence or presence of a specific substance, to fully quantifying every substance present in a sample. Drug checking can be done by stationary laboratories, or mobile labs at festivals or parties. While checking, it allows to provide drug counselling to PWUS who would not come to services otherwise. It is also a helpful tool to monitor illicit drug markets, trends and the emergence of new substances.



### Online Interventions

*Online interventions* are delivered online, include interactive elements and provide individual feedback to PWUDs. These can be self-guided or include contact with a professional. They are generally cost-effective and can be accessed at any moment, requiring only internet access, making it easier for PWUS to overcome obstacles to accessing treatment. There is strong evidence that online treatment interventions are effective for a variety of mental health issues like anxiety and depression, as well as for self-help interventions based on cognitive behavioural therapy (CBT) that aim to control and/or reduce alcohol use. Evidence of the effectiveness of online treatment interventions specifically for PWUS is scarce. Several online interventions have been piloted for people who use cocaine and ATS, although few have been evaluated thoroughly. The available evidence shows that online interventions, especially when combined with other therapeutic interventions such as a community reinforcement approach (CRA), contingency management or CBT, may help people stay in treatment, stay abstinent, and/or reduce drug use.



### Therapeutic Interventions

Therapeutic interventions are predominantly used in treatment settings aimed at abstinence but can also be powerful tools in a harm reduction environment, helping PWUS cope with (acute) mental health issues, cravings and to help with managing drug use. Mental health illness and problematic substance use frequently occur together. For more severe symptoms, crisis interventions by mental health professionals are recommended. Non-mental health professionals working with PWUS in a harm reduction setting can apply several simple techniques to aid PWUS suffering from paranoid thoughts, anxiety, hallucinations or withdrawal. Interventions such as CBT, contingency management, motivational interviewing, family therapy, CRA and brief interventions have proven to be effective in the treatment of cocaine and methamphetamine use. They can help people identify drug-related problems and commit to change, increase treatment adherence, reduce drug-related harms, help create a support network and manage drug use.

## Cases

The seven good practice cases represent 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 healthcare system, linkages with other (harm reduction) services, available resources, and geographical regions.



### **“Atitude”, an approach to housing first in Brazil**

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. Its purpose is to increase people's life quality, promote social protection, reduce criminality, and prevent incarceration. In 2017, the programme had a budget of 3.8 million euros and assisted 154,626 people in 4 different municipalities: Recife, Caruaru, Jaboatão dos Guararapes, and Cabo de Santo Agostinho. The programme offers four different services: outreach work, drop-in centre and night shelter, intensive (day and night) shelter, and independent social housing. A separate intensive shelter exists for females, welcoming especially mothers (to be) and female transgenders. In weekly meetings called assemblies, PWUS from drop-ins and shelters evaluate the services and decide, together with staff, on possible improvements. PWUD who are ready to have a more autonomous life and further integrate into society are offered independent social housing. A good amount of networking happens among the different services of Atitude programme, as well as with external social and health care services. The major cooperative challenges lie with the judiciary and the police, who still demonstrate difficulties in understanding and supporting harm reduction actions.

According to PWUD and the programme staff, Atitude is a great success among people who use crack cocaine 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, increase sociability and protection against violence, strengthen family relations and self-care, decrease anxiety, develop control and autonomy in their life, increase control over drug use and income generation. Especially for female users, strengthening the bond with their children was mentioned as an important achievement, as well as reflecting upon and/or decreasing abusive relationships.



### **“Chem-Safe”, an online intervention for chemsex users in Spain**

Chemsex emerged as a phenomenon in Spain around 2012; professionals working in the fields of sexual health, harm reduction, addiction care, male prostitution, and LGBT noticed that certain MSM were using drugs during sex. Cocaine, mephedrone and methamphetamine are the two stimulants most used by chemsex users and are frequently combined with other substances (such as GHB, Viagra, and ketamine). Chemsex soon became associated with risky (sexual) practices, transmission of infectious diseases, and with psychological issues around self-esteem, sexual orientation, internalised homophobia, loneliness and social isolation, as well as anxiety, depression, and other mood disorders. In 2016, harm reduction Energy Control collaborated with 11 organisations to create a platform dedicated to this group. An educational, harm reduction oriented website was developed, called Chem-Safe. The site provides objective information on substances, drug interactions, risks as well as harm reduction tips for this high-risk population. It also provides an online advice and support service, via email and video chat, and can refer men to other organisations and services. Everything can be accessed confidentially and anonymously. Chem-Safe is a pioneering service that has managed to establish links and facilitate the collaboration between different types of associations, something that's considered crucial to accomplish for such a complicated and novel phenomenon. This is especially useful in the face of sensationalist reporting on chemsex in mainstream media. Users express feeling taken seriously and often adapt their consumption patterns based on the health-based information they receive. Users appreciate having access to specific information on drug use in a sexual context, and on adverse

effects, risks, and interactions with medication or other substances. Despite these successes, political support to address the chemsex issue is lacking and the Chem-Safe project is fully volunteer-run, as it continues to suffer from insufficient (financial) support. Chem-Safe could be disseminated at a large scale, reaching more people who participate in risky chemsex practices. The network of linked services for chemsex users could be expanded and more formalised in the future.



### **“Contemplation groups”, an approach to self-regulation in South Africa**

Contemplation groups are group sessions for PWUD with a specific harm reduction focus. They were developed in Cape Town, South Africa, 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. There are eight to twelve differently themed 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 service: all you need for this intervention is a safe space and a facilitator. The facilitator does not have to be a psychologist but can also be a peer, as long as s/he is capable of supporting the group dynamic and individual contemplations. These groups can also 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.

The contemplation groups are 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 control their drug use when they do decide to use. The groups are open and flexible on the one hand, and on the other hand they feed into a strong group feeling, where a sense of family may arise and where SUs hold each other accountable for their behaviour. Acquiring this balance

requires some adjustments as a group develops, but experience has demonstrated that this is possible.



### **“COUNTERfit”, an approach to safer smoking kits in Canada**

COUNTERfit is a harm reduction programme based in Toronto that offers a range of services aimed at meeting the health and social needs of PWUD. It was the first in Canada to address the needs of non-injectors by distributing kits for safer crack and meth smoking. The programme started in 2000 and developed safer crack smoking kits with the involvement of various stakeholders and the local PWUS community. It is mostly funded by Ontario's state, with a contribution from Toronto's municipality. Since 2006, outreach work is done seven days a week, including evenings. Female specific services started in 2007. In the same year, COUNTERfit had over 22.000 service user visits and distributed almost 50.000 safer smoking kits. PWUD can get these at the COUNTERfit office, in one of the 10 satellite services offered by trained peers, or through the mobile programme, which delivers supplies to callers during evenings and weekends when the fixed site is closed. In addition to supplies, COUNTERfit offers harm reduction-based counselling, and confidential referrals to other health and social services. Specific programmes within COUNTERfit addresses the unique needs of women who use illegal drugs or who work in the sex trade, and PWUS with an aboriginal background. Other programmes provide collective activities to address social, health, and advocacy needs of PWUD, and address grief and loss. COUNTERfit has a yearly budget of approximately 325.000 euros. Service users and staff mentioned many achievements of COUNTERfit. It helped service users to develop social, learning, and leadership skills, as well as to feel more confident in themselves. Service users were happy with the materials delivered, delivery hours, information about smoking and injection given by staff, the relationship with staff, referrals to other services, and social integration support. Some challenges faced relate to the working hours and related life-style for mobile outreach workers doing night shifts, the impossibility of meeting the very high demand for services, and lack of supplies in some shifts. Some lessons learned in terms of supplies distribution included being ready for an unpredictable schedule, have enough supplies, keep

a low profile when on delivery, keep good records and always give PWUS options for their use. Staff also found useful to always have something to offer service users (such as coffee, a warm meal, or public transit tokens) to entice them to establish contact and stay connected with the programme.



### **“El Achique de Casavalle”, an approach to drop-in centres in Uruguay**

El Achique is a community-based listening, welcoming and proximity centre, or drop-in centre, that started in 2000, at the same time that the use of base paste cocaine suddenly exploded in Uruguay's capital. The drop-in centre's primary purpose is to work towards social inclusion, particularly of vulnerable young (mostly) males who use substances problematically, all within proximity of where they live. Work reintegration is a secondary goal, as this is considered essential for full reintegration into society. Substance use isn't addressed directly but is seen as symptomatic of deeper psychosocial issues such as abuse, marginalisation, poverty, and violence. El Achique provides a warm, safe, friendly and healthy environment that takes users out of life on the streets and the drug use scene, which is often chaotic and violent. For many users, the family-like atmosphere and solidarity between users are very important aspects of El Achique. Users can make use of psychological counselling, (health) education, and other activities such as cooking classes, workshops on construction, relapse prevention, and basic rights, and, when available, to work on opportunities. The psychologists actively work on empowering users by stimulating their self-esteem and autonomy. This helps users to develop self-control strategies. In fact, many users mention having significantly reduced or sometimes fully quit their substance use. Taking people out of the immediate risks posed by a chaotic and violent environment helps them with the development of health strategies to deal with substance use. In practice, providing access to work opportunities for service users is important but remains a challenge. El Achique is somewhat disconnected from other services for people who use drugs. Although it is an interinstitutional project supported by various government branches, political and financial support is unstable, which hampers the day-to-day implementation and planning of El Achique.



### **“Karisma's shabu outreach”, an approach to outreach work in Indonesia**

Karisma's *shabu* outreach is the first harm reduction outreach work project focused on assisting PWUS in the South East Asian region. It reaches out to people who use methamphetamine in the capital city of Jakarta, on Java island, in Indonesia. The programme started in mid-2016, financed by an international donor (Mainline) with an annual budget of 45.000 euros. Five outreach workers currently assist around 60 PWUS a day and peer educators are also involved to increase the programme's reach. Outreach provides PWUS with information and leaflets on meth, mental health issues, drug use and dependence, and the impacts of meth use on their health. Besides, since 2017, the team distributes safer smoking kits.

The project has been taking onboard many lessons learned throughout the process. Meaningfully involving PWUS, including peers 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 referring people who use meth to other (specialised) services. Working with mental health problems linked to meth use is particularly difficult. PWUS tend not to recognise their symptoms as mental health related, and services are not yet prepared to assist the population. The strict drug regulations in Indonesia, along with a harsh police approach, also makes PWUS suspicious of new contacts, requiring the team to have many repeated contacts with the same individuals to build trust. However, there is a strong partnership with human rights and legal protection services, primarily to support PWUS who are in trouble with law enforcement.

Despite the challenges, PWUS assisted by the programme are very satisfied. They especially value the kits distributed and the information received on methamphetamine, harms, and diseases such as TB, HIV and Hepatitis. 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. Many service users referred to have reduced, stopped, or achieved a better control over their meth use, along with being more aware of and

reducing sexually-related risks. The programme also helped them to increase self-care and self-esteem and got them interested in looking beyond drug use alone.

This case showed that 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. At least in an initial phase, this 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.



### **“Princehof, Ripperdastraat and Schurmannstraat”, approaches to Drug Consumption Rooms in the Netherlands**

Drug consumption rooms (DCRs) are professionally supervised healthcare facilities where PWUD can consume drugs in safer conditions. By offering safe and hygienic spaces for drug consumption, the risks of (public) drug use are reduced and access to hard to reach marginalised drug users increased. The setting allows for more open conversations about drug use, harm reduction and lifestyle. Moreover, it allows for distribution of paraphernalia, access to services and harm reduction practices while using.

The first DCR in the Netherlands was founded in 1995. Since then new DCRs have continued to open, with a peak in 2004-2005. In early 2018, the Netherlands counted 26 DCRs in 21 different cities. This inventory does not include the supported/sheltered housing facilities with a drug consumption room for its residents, which have been on the increase in recent years.

In contrast to DCRs 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.

We studied 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. These cases demonstrated that when integrated in a network of health and social services DCRs can not only offer a safe space, but also function as a starting point for health (and social) recovery.

## **Conclusions**

To a large extent, harm reduction for PWUS follows the same fundamental principles as for other substances. 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. (Problematic) substance use does not take place in a vacuum, but rather in a specific social, cultural, economic, legal, policy, and political environment. It can be both a public health and a social problem and it needs structural solutions. Maintaining control over one’s use, and managing both individual and social harms, depends on external mechanisms, such as rituals, social controls and other social factors. These include unemployment, poverty, homelessness, violence, unstable housing, incarceration, drug impurities, (lack of) availability of high quality harm reduction services, drug legislation, law enforcement practices, and public policies.

Inclusive harm reduction requires a re-centring of the focus on sustainable human development. Interventions that focus on housing first and drop-in centres, are also able to decrease stimulant use and promote more controlled consumption patterns.

### **Stimulant specific aspects**

Several aspects and interventions are specific to stimulant use. They are often related to the sleep deprivation resulting from prolonged use - particularly (acute) mental health issues, such as paranoia,

hallucinations and anxiety. Addressing these is important but can be challenging, especially where mental health issues are still strongly stigmatised, and where proper mental health care is not available. Specific harm reduction strategies include stimulating safer sex, a healthy sleeping pattern and healthy diets, preventing dehydration, taking care of general and dental hygiene, and smoking stimulants in a safer way. There are also specific strategies for pregnant women using stimulants. Many studies offer proof for the efficacy of harm reduction strategies for stimulants, and the 12 strategies described in this report are the ones we found to have most evidence available.

### The case studies' valuable lessons

- Although a stimulant drug may be people's primary drug of choice, poly-drug use is common, and must be addressed. PWUS in this study often also used alcohol, GHB, opioids, cannabis and/or prescription depressants.
- It is possible to empower users to develop strategies that increase self-care, improve their health, sense of self-worth and promote control over their substance use by stimulating their autonomy, self-esteem, accountability and solidarity with others.
- Providing care for mental health issues is especially relevant for people who use stimulants. Handling psychotic episodes, depression or unpredictable and aggressive behaviour is difficult. Basic mental health training can help frontline staff respond adequately, which is particularly important if specialised mental health care is not available or underdeveloped.
- Providing low-threshold services, by creating a warm, safe, friendly and welcoming atmosphere, is very important to reach people who often come from an environment of social exclusion, violence, economic vulnerability and unstable family situations.
- Providing structure, a sense of family, belonging and acceptance, as well as participation in meaningful activities, can give users a sense of purpose and may be effective to counter feelings of worthlessness, loneliness and lack of (social) structure that people often have.
- Substance use can be symptomatic of deeper psychosocial, economical or cultural issues, including marginalisation, homelessness,

isolation, joblessness, poverty, and violence. For meaningful and enduring reintegration into society, structural harm reduction strategies that focus on environmental risks are needed. Such strategies include the provision of stable housing, and a fixed source of income.

- Good linkages to other relevant (health and social) services are very important. None of the case studies we described provided a service in isolation. Better integration, or better linkages between complementary, friendly services would improve harm reduction interventions.
- Irrespective of the social or cultural context, or the specific substances used, meaningfully involving peers from the same social group is key in connecting with (new) groups of people who use stimulants, especially in outreach work. An open, welcoming and non-judgmental attitude is fundamental to establishing a good and trust-worthy relationships.
- 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.
- In outreach work, having something concrete to offer besides information is important: this can be as basic as water, a hot meal, or harm reduction materials such as safer smoking kits.
- Pioneering novel harm reduction interventions for a population that has not received services before is challenging, particularly in repressive contexts. This requires extra effort in establishing connections with the population but also with other services.

## Recommendations

There are many ways to promote the availability of evidence-based information and practices on harm reduction for PWUS. Most importantly, we need more research, better monitoring of impact, sharing of best practices and funding for inclusive harm reduction services. Future research could look at mental health for people who use stimulants, for instance, investigating how approaches promoting self-control (such as mindfulness) can be used to improve quality of life of PWUS. How to improve access and effectiveness of mental health services for PWUS, especially in resource-poor areas and

settings with less developed mental health facilities, is also recommended. Regarding gender-based research and interventions, more could be done to also include men to gender based interventions and initiatives, reflecting on their role and responsibilities. This could lead to concrete recommendations on how to include reflections on masculinity, gender relations and fatherhood in harm reduction programmes.

New studies on good practice cases should also consider documenting interventions that were not included in this report. These could be interventions that address the adverse effects of sleep deprivation such as chill-out zones and other interventions in party settings; interventions for people who use novel stimulants including cathinones; and substitution practices. We also recommend providing practical guidelines to facilitate setting up high quality harm reduction services for people who use stimulants. These should include guidance on training harm reduction and health care staff on mental health issues. Finally, evidence for the efficacy and/or cost-effectiveness of most harm reduction services we studied - including the most successful and long-running interventions - is scarce. Introducing basic monitoring and evaluation tools can help measure impact on self-control, frequency and amount of substance use, but also 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.

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