HARM REDUCTION PRACTICE : IT'S APPLICATION AND EFFECTIVENESS FOR PSYCHOTROPIC SUBSTANCE

HKCSS

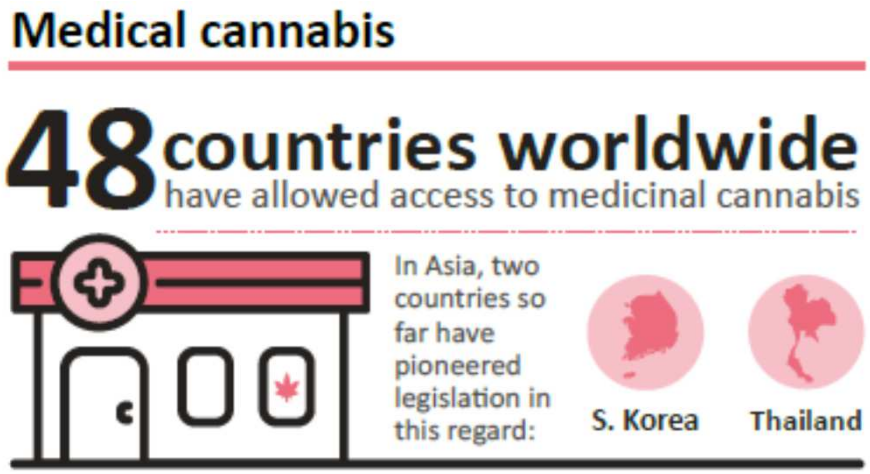
2 June 2020

Karen Joe Laidler, Centre for Criminology, HKU

Figure 2. Availability of harm reduction services in Asia

Credit: Stone, K. & Shirley-Beavan, S. (2018). Global State of Harm Reduction 2018 (London: Harm Reduction International)

Source: IDPC (2019) *Taking stock: A decade of drug policy - A civil society shadow report*



Source: IDPC (2019) *Taking stock: A decade of drug policy - A civil society shadow report*

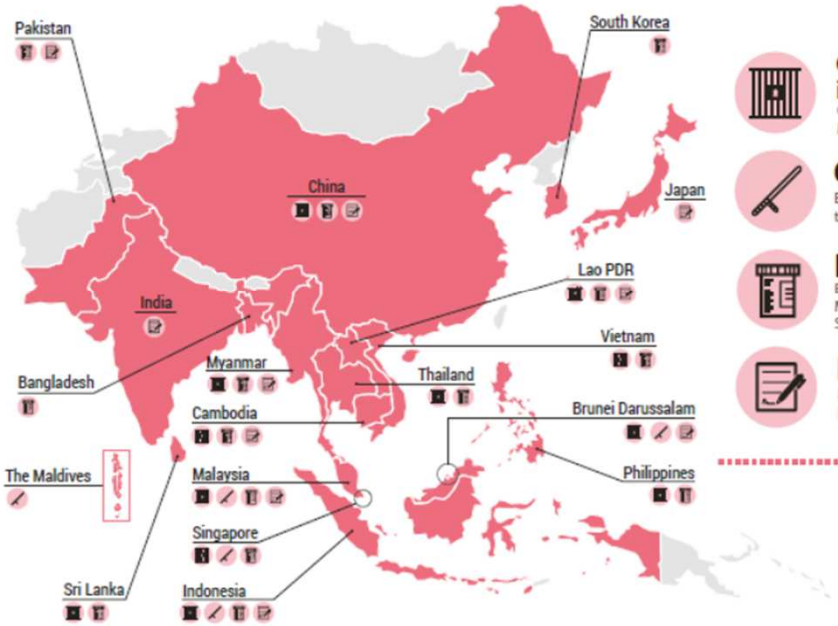
Death penalty

16 countries in Asia

retain the death penalty for drug-related activities.

= ½ the total number of retentionist countries worldwide.

Torture and cruel punishment



Compulsory *rehabilitation* in detention
Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Vietnam

Corporal punishment
Brunei Darussalam, Indonesia, Malaysia, the Maldives and Singapore

Forced urine testing
Bangladesh, Cambodia, China, Indonesia, Lao PDR, Malaysia, Myanmar, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Thailand and Vietnam

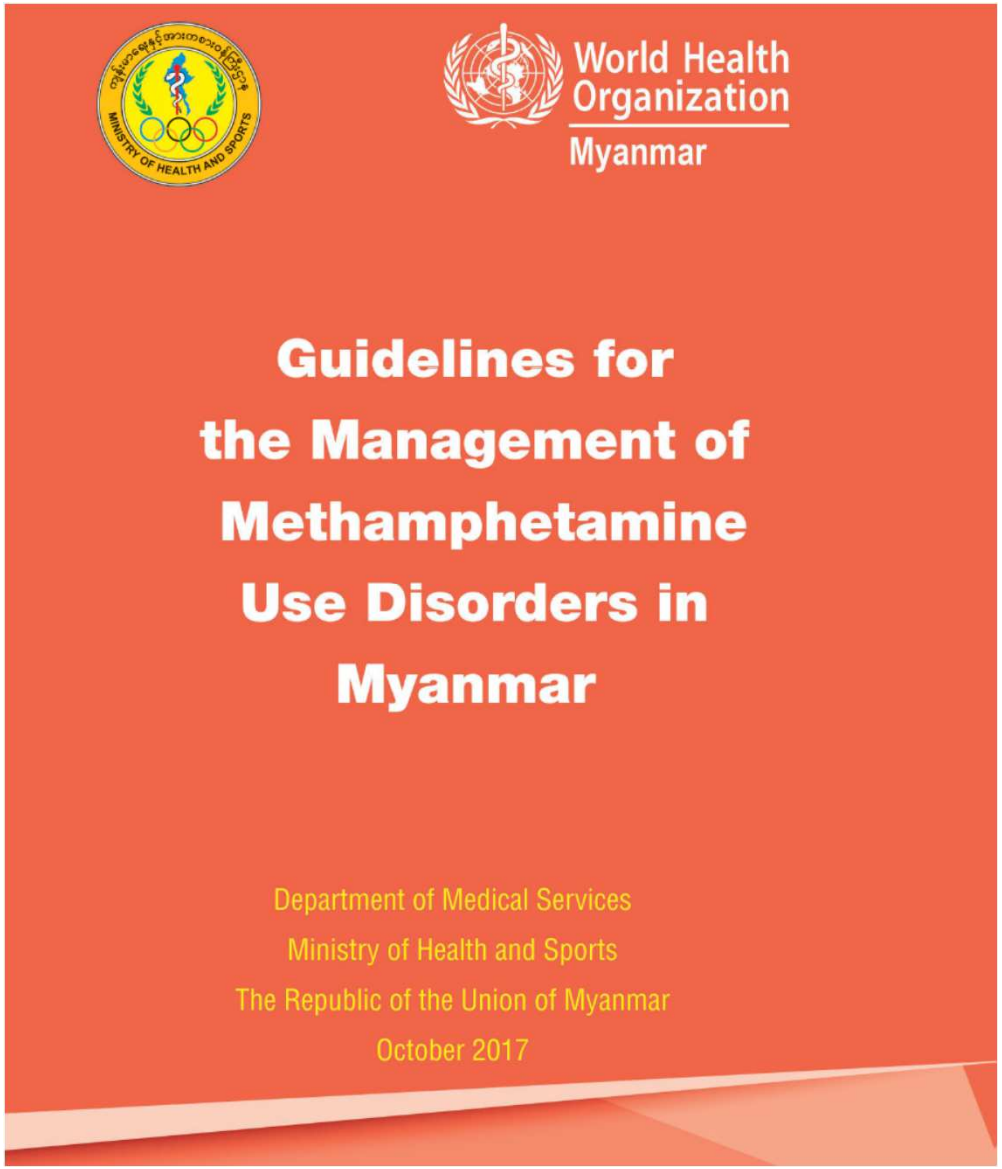
Mandatory registration
Brunei Darussalam, Cambodia, China, India, Indonesia, Japan, Lao PDR, Malaysia, and Pakistan

Administrative punishment
can also amount to acts of torture or cruel treatment

Source: IDPC (2019) *Taking stock: A decade of drug policy - A civil society shadow report*

Figure 1: Estimated number of people who use drugs in Asia, 2011-2016, in millions

Source: IDPC (2019) *Taking stock: A decade of drug policy – A civil society shadow report*



http://www.anpud.org/guidelines-management-methamphetamine-use-disorders-myanmar/

HARM REDUCTION (HR)

1. Harm reduction for frontline workers
2. Harm reduction strategies for different types of drugs

What is HR in the context of social work?

- An approach that includes strategies to reduce risks and harms for the individual and community

- Challenges:
  - Reconciling HR with the dominant disease model of abstinence only treatment. Where does one start then?
  - Some see drug misuse as better dealt with doctors, psychologists and addiction counselors, not social workers.
  - Experience role conflict as work within parameters of social control system (because of drug policy) and client's advocate.

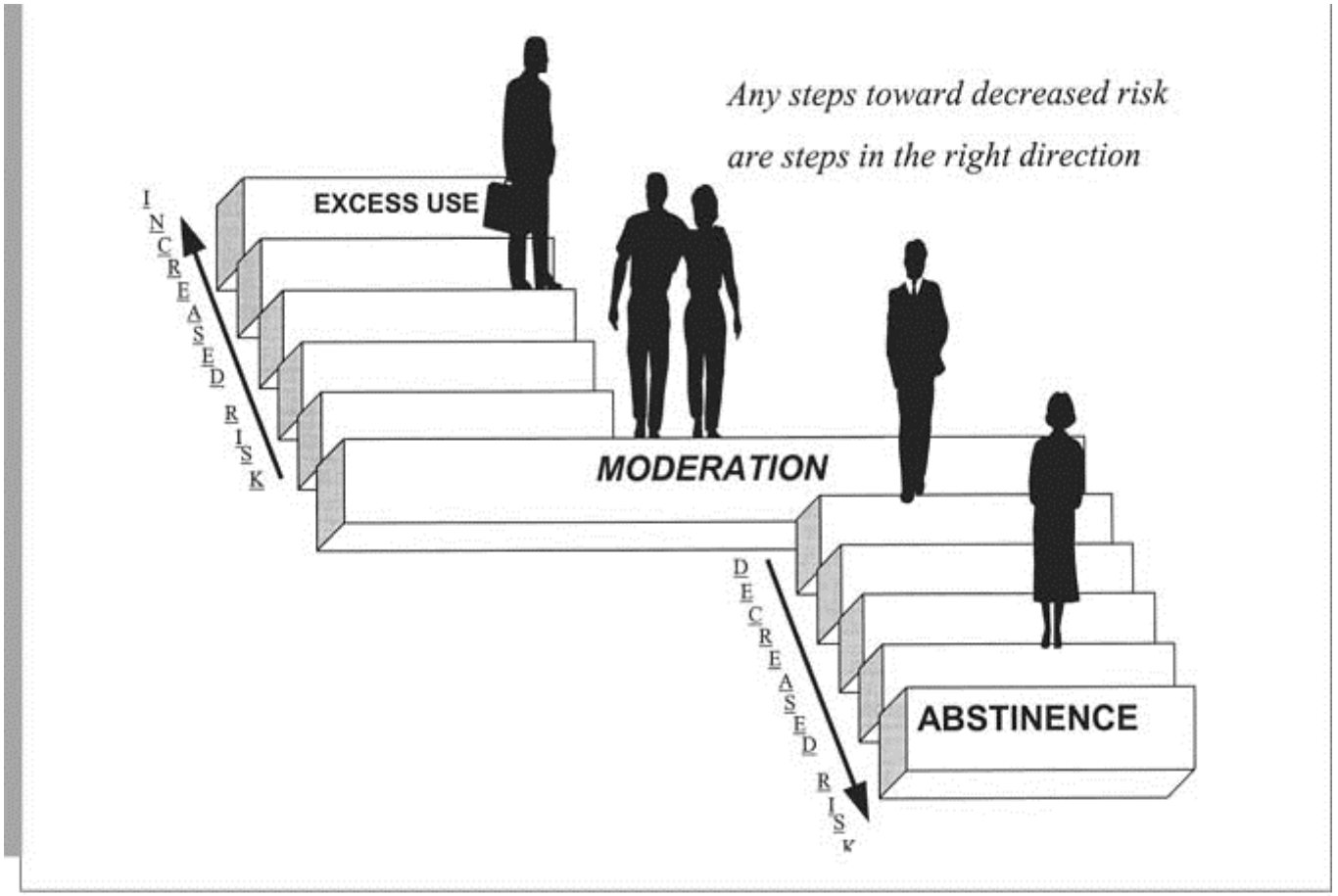
What does this mean in practice for social workers? Guiding principles

1. Be pragmatic
2. Adopt humanistic values
3. Give priority to the person – a holistic focus on the physical, psychological, social, economic and legal rather than zeroing in on drug use.
4. Develop a treatment strategy together
5. Give priority to reachable and realistic goals

So how to do this?

HR strategies: Incremental steps

(source Marlatt, Blume and Parks, 2001)



SOURCE: Courtesy of Jessica Cronce.

See also Sobell and Sobell (2000) on “Stepped Care” approach

Starting from where the client is

(Vakharia and Little 2016)

1. Create alliance
2. Lower thresholds for services and treatment
3. Convey neutrality towards drug use
4. Explore client's relationship with drugs
5. Ensure client feels like s/he is part of the collaborative process in treatment

Harm reduction strategies by drug types

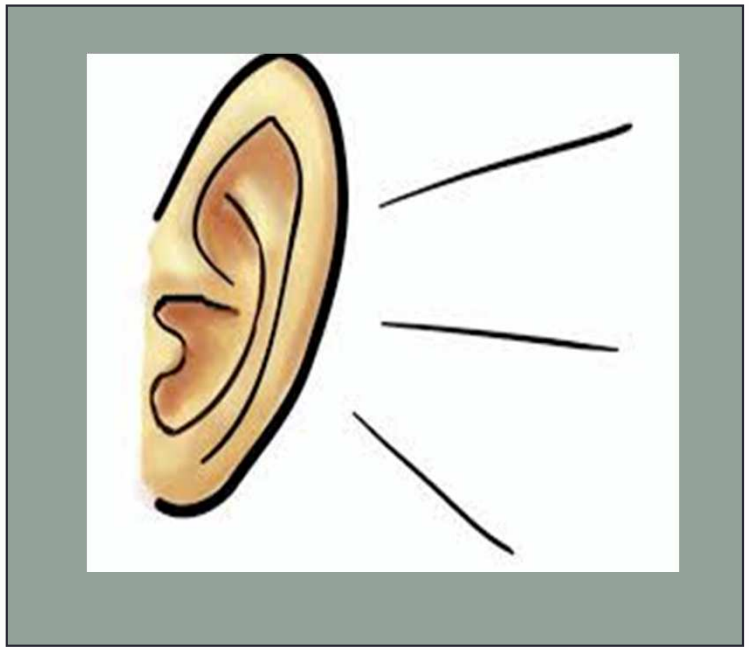
But first, some reminders:

- What is the most important aim of HR? To reduce harm! Reduction or cessation of use is secondary.

THE DAILY NEWS

www.dailynews.com THE WORLD'S FAVOURITE NEWSPAPER - Since 1879

Harm reduction is here



Many drug users engage in harm reduction practices…

We just don't understand it as such OR we just aren't hearing them!

Obtain knowledge from:

1. Experiential (self awareness)
2. Observation (watching & listening to others)
3. Doing research (least used)

CANNABIS

Use Practices	Harms	Strategies
Early onset (<18)	Linked to higher risk of dependence & problem outcomes. In youth, impairs brain development, cognitive functioning, and behavioral impulsivity. Mental health problems include depression, psychotic symptoms. These links have not been found for those initiating after 18 yrs. of age.	Prevention and early intervention information: later onset of use is associated with lower risks to general health and development.
Use of strong THC levels (20 to 25%) Use of synthetic cannabinoids (80 to 90% THC)	Strong THC linked to acute and chronic adverse effects especially mental health issues and dependence. Effects on memory, paranoia, dependence Synthetics like Spice, linked with severe cognitive impairment, psychosis, anxiety, strokes, seizures, nausea, fatalities.	Information for users: learn about the nature of the cannabis used, lower levels of THC present less risks. Learn about the adverse and serious risks to health. Avoid as THC levels can be toxic.

CANNABIS

Route of administration: Smoking	This route associated with pulmonary and bronchial problems (coughing excessive sputum, wheezing, shortness of breath), impairment of respiratory functioning. Found to be reversible upon quitting. Deep inhalation or breath holding (to increase sensation) can result in intake of carcinogens and other toxins, and intensified by simultaneous use of tobacco. Bongs & water pipes can reduce particle inhalation but increase intake of tar and other matter. Infectious diseases (like TB) also found linked to this route, related to sharing equipment.	Information for users: learn about the range of routes of administration from the most potentially harmful to the least harmful with details on what those effects are. Smoking blunts, bongs and pipes are commonly used but associated with respiratory problems & infections. Vaporizers have been shown to reduce this problem, but the slow uptake may result in higher doses. Deep inhalation and breathing should be avoided to decrease toxins entering the blood stream. Edibles negate respiratory problems but the slower uptake may result in consuming higher doses and increase other risks like cognitive impairment.

CANNABIS

Frequency and Intensity of Use	Higher levels of use and intensity are linked to chronic health problems. Frequent use (e.g., nearly every day) linked to problems related to mental health, heart, suicidality, neurocognition, alterations of brain structure	Information for users: frequency of use is related to health related short and long term problems. Be aware, record and reflect on frequency of use, aiming to reduce to occasional (e.g., once a week, weekends).
Mobility/driving	Linked to psychomotor impairment reduces ability to manage unexpected or emergency situations and environments. Upon intake, THC peak occurs between 5 to 30 minutes and gradually decreases 2 to 4 hours after. Cognition impairment may last longer from 3 to 6 hours.	Information for users: Avoid situations (often public) during peak periods to avoid problems with impairment and coordination. Avoid combining with alcohol as this further impacts impairment.

MDMA

Use practices	Harms	Strategies
Initiation	Potential allergic reaction due to deficiency of liver enzyme. Can result in increased effects and overheating Unpredictable reaction (and dependent on situational context)	Gradual uptake. First time try a quarter of a dose to test for reaction. Use in safe setting with peers who can provide help and guidance
Use with little/no knowledge of quality	Adulterants may result in unpredictable physical and psychological reactions	Testing kits Buy direct from a regular dealer or with reliable peers for quality control. Using only with friends Using only after others have tried Examine pills, taste or lick first

MDMA

Frequency and intensity	Jaw clenching, muscle tension, teeth grinding	Moderate use, spread use over duration of event or long period of time Dissolve under tongue rather than swallow
Use in party or physically exerting activities	Faintness Overheating and dehydration	Take magnesium supplement before and during use, acts as a muscle relaxant. Regular 15 minute breaks for every hour from physical activity, isolate in a cool quiet room, drink water (approx. .5 liter). But avoid more as may lead to over hydration (blood dilutes from too much water).
	Water retention (inability to urinate)	Drink electrolytes rather than water.

Poly drug use MDMA	With cannabis – can lead to disorientation With alcohol – counteracts euphoria and clarity, and further causes dehydration, impairs cognition With stimulants – overexcites central nervous system, increasing heart rate, blood pressure Commonly reported negative effects from mixing range of drugs and alcohol at festivals (international survey, 2019): Bad mood (depression) Headaches Memory impairment Insomnia Rapid heartbeat Decrease blood pressure Vomiting, Nausea Sexual difficulties Chest pain Injuries Loss of consciousness Fights/attacked	Be aware and moderate Avoid Avoid Self-reported HR : Avoid mixing depressants (shown to decrease likelihood of headaches, loss of consciousness, drop in blood pressure, injuries, and fights) Avoid mixing stimulants Set limits on quantities used (shown to decrease likelihood of bad mood and sexual difficulties, injuries, and fights) Take smaller doses Use lower quantities when mixing Wait for effects of dose to subside before reuptake

MDMA

Group nature of use	One drug used for and in social settings. Peer pressure	Be with close friends and those with prior experiences, be amongst the "right people" in the "right environment." Develop in group and out group practices In group – Establish plan for the event, including designated individuals to support in emergency and throughout event Awareness of others wellbeing – water levels, rest, pressure on over consumption, using equal amounts. Out group – Provide support for new comers (what to expect, monitor) Not discussing use with outsiders (safety)

MDMA

Post use	Hangover feeling – depression, sadness, unstable mood, insomnia, low motivation because drug stimulates serotonin and after using, is depleted.	Regulate and pace dosage Take the next day off from work Take supplements post subsequent to use event, 5-HTP (stimulates serotonin)

Practices	Harms	Strategies
Frequency & intensity KETAMINE	Range of recreational (weekend, non-dependent) to chronic users Cognitive impairment Short term dizziness, confusion, blurred vision, paranoia, insomnia, memory problems, stomach pain **Specific to chronic & high dosages** Ulcerative cystitis – thickening of bladder wall High blood pressure Respiratory problems Kidney dysfunction K cramps – severe stomach pain Depression & lethargy Psychosis Persistent feeling of being detached from reality Intense loneliness Tolerance User perceptions of dependence	Know your product to avoid adulterated products and learn about drug effects. Online sites/forums for knowledge and support Test kits Set limits on doses* Space out doses within an event* Space out sessions* Designated support person (whose sober) Chronic – use less in amount and in frequency to reduce problems related to bladder functioning. Hydrate and urinate frequently to keep drug moving and flushing from body, reduce further aggravation to bladder. Avoid acidic foods & drink to reduce further irritation to bladder & stomach Harms warning sign to “slow down” and use in safer and smarter way.

Ketamine

Route of administration	Snorting – irritate & damage nasal lining, bladder problems	Ensure powder is finely grounded, use nasal irrigation sprays Use clean equipment (not dollar bills) to avoid bacterial transfers and infections Limit doses to reduce bladder damage via this route
	Oral – pill – physical effects longer, bladder problems	Eat on a full stomach so the effects are better timed (on full stomach), limit doses
	Injecting (rare) – infections, respiratory problems	Avoid sharing needles, use clean equipment Shift or alternate with other methods Limit doses to reduce respiratory problems

Ketamine

Setting/circumstances of use	Dissociative effective & cognitive impairment increases risk of accidents and injuries Increased likelihood of unsafe sex	Go to safe chill out areas to consume and reduce risks Use in controlled private settings
Poly-drug use	Often used in combination with other drugs Depressants/sedatives affect/restrict breathing (lose consciousness) Stimulants increase heart rate and blood pressure Psychedelics strengthens the experience	Avoid mixing Use single drug for different settings and occasions

Why do people like meth?

Practices	Harms	Strategies
FREQUENCY AND INTENSITY		
Lack of food intake, eating junk food only	Malnutrition, dehydration	Provide water, juice and healthy foods
Low intake of water, forget to brush teeth, eating sugary food, and teeth grinding	Increased risk of anxiety, paranoia, and psychosis	Stress importance of sleep or rest in dark room
METHAMPHETAMINE	Need for higher doses to achieve same effects	Stress importance of hydration and dental hygiene
	Intensified crash	Distribution of dental kit with toothbrush and tooth paste
	Dry mucous membranes, more vulnerable to infections	
	Dental problems	Above strategies should be part of the information on how HR can have immediate positive effects when using.
Binging (prolonged sessions)	Increase risk of psychosis, paranoia, anxiety and other health problems	Encourage making a plan for breaks, assist in developing methods to help keep track of how long and how much they use, establish rules and limits, and have a HR buddy to support.
		Stress that depression, fatigue, moodiness and aches are natural part of withdrawal and will pass
Heavy Use	Withdrawal and crashes	Stress that focusing on pleasant and distracting activities, keeping close to supportive people and maintaining healthy diet and routine will help manage withdrawal and crashes

ROUTES OF ADMINISTRATION Sharing mouthpieces Smoking toxic materials Using pipes that can result in burns	Risk of blood borne diseases, lung damage, toxicity, cuts, burns	Distribute smoking kits and information on safer use Distribute glass stems with gauze or individual pipe tips Distribute lip balm and burn salve

FUNCTION OF USE		
Sexual Risk	HIV and STIs	Free access to condoms, lubricants and information about HIV and STIs Stress importance of using lubricants during long, dry or rough sex Develop a sexual harm reduction plan in advance, discuss realistic ways to reduce sex related harms Talk about sexual and physical violence, and other issues related to sexual risk behaviors.
Weight control	Dependence, excessive weight loss, other harms associated with use	Discuss fear of weight gain and help develop plan to manage weight gain and explore underlying poor body image. Reminder that drug initially helps sustain attention and endurance, heavy use eventually makes it difficult to complete tasks, focus or behavior appropriately in work and study settings.
For Work or study		Organize separate support groups to respond to needs of people who use the drug for different reasons (truck drivers, teens, sex workers).

A range of harms is associated with amphetamine use. Some are predominantly dose related and others are a combination of dose and length of use.

Physical consequences of low-dose use	Physical consequences of high-dose use	Physical consequences of short-term use	Physical consequences of long-term use	Physical consequences of ATS use
- Sweating - Intoxication - Palpitation - Chest pain - Headache - Hot and cold flushes - Reduced appetite - Increase in blood pressure - Euphoria - Alertness - Reduction of fatigue - Talkativeness - Improved physical performance	- Overdose - Intoxication - High blood pressure - Seizures - Nausea - Vomiting - Cerebral haemorrhage and death	- Intoxication - Dehydration - Cardiovascular problems (i.e. rapid heart rate, irregular heartbeat and increased blood pressure and death from a cardiac event) - Overdose - Hyperthermia and convulsions - Decreased appetite and weight loss - Skin and teeth problems - Sleep disorders - Feelings of invincibility while intoxicated - Increased high-risk behaviours such as unsafe sex	- Drug dependence - Poor nutrition - Poor sleep - Susceptibility to illness including cardiovascular problems - Potential death from arrhythmias or myocardial infarction or stroke	- Precipitates psychiatric problems - Exacerbates existing problems - Mood disorders: confusion, paranoia, anxiety, depression, suicidal ideation, panic attacks, obsession, psychosis - Cognitive impairment - Sleep disorders, fatigue - Agitation - Increased impulsivity - Aggression and violence - Social and family disruption /breakdown - Unemployment

Source: Adapted from the Australian ATS strategy[10]

From: WHO (2011) Technical Brief on ATS. Report 1

Steps for developing harm reduction services for ATS users in the community[7]

STEP ONE: Preparation

Conduct a "needs assessment" review based on research and "good practice".
Collect strategic information.
Identify what interventions are needed.
Consult with ATS users, ensuring their meaningful involvement in the planning and delivery of services.
Identify acceptable interventions and innovative ways of reaching ATS users.
Plan staff recruitment and training.
Address barriers to support help-seeking behaviours among ATS users/examine legal and policy frameworks.
Explore a multifaceted/comprehensive approach. Integrate research and evaluation into services.
Establish clear targets and objectives.
Conduct advocacy with the community and law enforcement officials, and assess the capacities and resources in the community.

STEP TWO: Services

Outreach and peer education:

- Provide culturally sensitive and clear messages. These should be integrated and consistent, accurate and relevant to ATS users, highlighting the risks of injecting and acquiring bloodborne diseases from sharing contaminated equipment. Include the following messages:
  - Use less ATS and less often (drink water, eat fruit, improve diet, get adequate rest, employ strategies to help control drug intake, monitor own behaviours, do not use alone).
  - Avoid using ATS with other psychoactive substances (e.g. alcohol to help "come down" from ATS).
  - Do not inject – switch from injecting use back to oral use – if injecting, do not share.
  - Use a condom every time you have sex.

Targeted interventions for specific groups of users

- (e.g. injectors and non-injectors, youth, women, minorities)

Provision of equipment to help behaviour change (condoms, needles and syringes)
Low-threshold advice and brief counselling to ATS users and families (see next page)
Establishing links and a referral network to health and welfare facilities

From: WHO (2011) Technical Briefs on ATS. Report 2.

Meth harm reduction in action in Asia

	Users' HR practices and advice **From Cachia and Lwin (2019) Methamphetamine Use in Myanmar, Thailand and Southern china: Assessing practices, reducing harm. TNI.**
1	Avoid using meth, but if you're going to use, know your limit. If you use too much, you will no longer enjoy the positives of meth, and only the harms will increase.
2	Use slowly, wait and space out the time between uptakes, try to avoid daily use.
3	Avoid using if in a bad mood, using can make you feel worse.
4	Set some basic rules for yourself, and try to stick to them like deciding in advance how much you will use and for how long, and which days you are not using.
5	Take breaks, especially after heavy use, and eat and sleep to let your body recover
6	Sleep at least a few hours every day, otherwise this will affect your health and make you feel bad.
7	Eat a full nourishing meal before using, as you won't be hungry after.
8	Drink plenty of water as you'll get dry mouth, and try to brush teeth after using.
9.	Do not share smoking equipment to prevent transmission of infections and diseases.

Meth harm reduction in action in Asia

"Adapting safer smoking kits to local circumstances"
Rigoni, Woods, and Breeksema (2019) "From opiates to methamphetamine: Building new harm reduction responses in Jakarta, Indonesia"
Harm Reduction Journal 16:67.

Suggested contents of a “safer crystal methamphetamine smoking” kit based on Canadian project

Item	Reasons and comments
• 1-2 Pyrex or tempered glass pipes	• To prevent breakage
• Lighter	• Torch lighters preferred
• Scoops	• To put crystal meth in bowl
• Scrappers	• To scrape out residue
• Alcohol wipes	• To clean pipe after use • For “chasing the dragon”
• Tin foil and straws • Hand sanitizer • Condoms	
• Lubricant	• For oral hygiene concerns
• Mouthwash	• For cracked lips
• Lip balm	
• Band-Aids	• Many people would not use
• Rubber mouthpieces	• For dry mouth
• Gum	• Since not eating much
• Electrolyte powder	• With information about health risks, crisis phone numbers, etc.
• Educational pamphlet	

Table 2, Extract from Hunter et al., (2012) Reducing widespread pipe sharing and risky sex among crystal methamphetamine smokers in Toronto. *Harm Reduction Journal.* 9:9.

From NoBox

References and resources:

Brocato, J., & Wagner, E. F. (2003). Harm reduction: A social work practice model and social justice agenda. *Health & Social Work*, 28(2), 117-125.

Denning, P and Little, J. (2012) *Practicing harm reduction psychotherapy: An alternative approach to addiction* (2nd. Edition). NY: Guilford Press.

Fernández-Calderón, F., Díaz-Batanero, C., Barratt, M. J., & Palamar, J. J. (2019). Harm reduction strategies related to dosing and their relation to harms among festival attendees who use multiple drugs. *Drug and alcohol review*, *38*(1), 57-67.

Fischer et al., (2017) Lower risk cannabis use guidelines: A comprehensive update of evidence and recommendations. *AJPH Policy*. 107(8): e1-e12.

Hunter, C., Strike, C., Barnaby, L., Busch, A., Marshall, C., Shepherd, S., & Hopkins, S. (2012). Reducing widespread pipe sharing and risky sex among crystal methamphetamine smokers in Toronto: do safer smoking kits have a potential role to play?. *Harm reduction journal*, *9*(1), 9.

International Drug Policy Consortium (IDPC) (2019) *10 Years of Drug Policy in Asia: How Far Have We Come. A Civil Society Shadow Report*. IDPC: Bangkok, Thailand.

IDPC (2015) A Guide to MDMA Harm Reduction. https://idpc.net/alerts/2015/02/a-guide-to-mdma-harm-reduction

Katzman, J. (2020) Harm reduction, Part 10: Ketamine harm reduction strategies. Accessed at: http://www.jessicakatzman.com/blog/harm-reduction-part-ten-ketamine-harm-reduction-strategies

Marlatt, G. A. and Witkiewitz, K. (2010) Update on harm reduction policy and intervention research. Annual Review of Clinical Psychology. 6:59111-606.

Morgan, C. J., Curran, H. V., & Independent Scientific Committee on Drugs (ISCD). (2012). Ketamine use: a review. *Addiction*, *107*(1), 27-38.

Panagopoulos, I., & Ricciardelli, L. A. (2005). Harm reduction and decision making among recreational ecstasy users. *International Journal of Drug Policy*, *16*(1), 54-64.

Pinkham, S., & Stone, K. (2015). A Global Review of the harm reduction response to amphetamines: a 2015 update. *London: Harm Reduction International*.

Rigoni, R.,Woods, S., and Breeksema, J. (2019) "From opiates to methamphetamine:
Building new harm reduction responses in Jakarta, Indonesia"
Harm Reduction Journal 16:67

Sharifimonfared, G., & Hammersley, R. (2019). Harm reduction and quitting techniques used by heavy MDMA (ecstasy) users. *Addiction Research & Theory*, 1-9.

Sobell, M. B., & Sobell, L. C. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. *Journal of Consulting and Clinical Psychology*, 68(4), 573-579.

Subritzky, T. (2018) Beyond deficit and harm reduction: Incorporating the spectrum of wellness as an interpretive framework for cannabis consumption. *International Journal of Drug Policy* 60: 18-23.

Swift, Jan Copeland, Simon Lenton, W. (2000). Cannabis and harm reduction. *Drug and Alcohol Review*, *19*(1), 101-112.

Tackett-Gibson, M. (2008) Constructions of risk and harm in online discussions of ketamine use. *Addiction, Research and Theory*. 16(3): 245-257.

Vakharia, S. P., & Little, J. (2017). Starting where the client is: Harm reduction guidelines for clinical social work practice. *Clinical Social Work Journal*, 45(1), 65-76.

Vidal Gine, C., Fernández Calderón, F., & Lopez Guerrero, J. (2016). Patterns of use harm reduction strategies, and their relation to risk behavior and harm in recreational ketamine users. *The American journal of drug and alcohol abuse*, *42*(3), 358-369.

WHO (2011) Technical Briefs on ATS (1-4) Accessed at https://www.who.int/hiv/pub/idu/ats_tech_brief/en/