

## Harm reduction and brief interventions for ATS users

*This brief outlines public health interventions directed at those who use amphetamine-type stimulants (ATS). Research indicates that the majority of ATS users are casual/experimental users who do not require intensive treatment interventions. Instead, they require information and counselling to enable them to appreciate the potential risks from ATS use and take measures to mitigate these harms.*

Although the majority of countries in Asia have embraced *harm reduction* as a legitimate drug treatment approach, harm reduction services that target ATS users in the region are scant. The most prominent interventions for ATS users are *compulsory* residential centres whose treatment goal is abstinence. ATS users are either apprehended by the police or brought to these facilities by concerned relatives without “due process”, i.e. through the judicial system, and frequently against the expressed wishes of the user. This approach to the treatment of ATS use is widely followed in the absence of alternative treatment options. At least a quarter of a million drug users are incarcerated in such centres at any one time.<sup>1</sup> There have been few formal evaluations as to the effectiveness of these centres. In most cases, the centres focus on very basic and symptomatic drug detoxification and physical exercise, and pronounce drug users to be “cured” once that process is completed. There is inadequate information on what happens to ATS users when they leave the centres. However, a review of the existing evidence “points to the conclusion that the empirical evidence for the effectiveness of compulsory treatment is inadequate and inconclusive”.<sup>2</sup> Moreover, there is emerging evidence in the region of serious human rights abuses in these facilities.<sup>3,4</sup>

There is a strong case to be made for applying harm reduction approaches to the problems faced by ATS users. It is estimated that just 11% of ATS users becomes dependent and requires specialist interventions; the majority do not.<sup>5</sup> It is likely that even occasional non-dependent users may experience physical, social or psychological harm from their ATS use, and indeed may progress to more harmful or intensive drug use. They would thus benefit from interventions designed to mitigate the potential harm from their ATS use and concomitant lifestyle.

1 WHO, UNAIDS, UNODC, The Global Fund, ANPUD. *A strategy to halt and reverse the HIV epidemic among people who use drugs in Asia and the Pacific 2010–2015*. Geneva, WHO, 2010. ([http://www.searo.who.int/LinkFiles/Publications\\_Harm\\_Reduction\\_Strategy2010-2015.pdf](http://www.searo.who.int/LinkFiles/Publications_Harm_Reduction_Strategy2010-2015.pdf), accessed 01 January 2011).

2 Wild TC. Social control and coercion in addiction treatment: towards evidence-based policy and practice. *Addiction*, 2006, 101: 40–49.

3 The Nossal Institute for Public Health, Open Society Institute Public Health Program. *Detention of methamphetamine users in Cambodia, Laos and Thailand*. Open Society Institute, 2010. ([http://www.soros.org/initiatives/health/focus/ihrd/articles\\_publications/publications/detention-as-treatment-20100301/Detention-as-Treatment-20100301.pdf](http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/detention-as-treatment-20100301/Detention-as-Treatment-20100301.pdf), accessed 01 January 2011).

4 Human Rights Watch. “*Skin on the Cable*”: the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia. *Cambodia*, Human Rights Watch, 2010. (<http://www.unhcr.org/refworld/country,,,KHM,,4b61771b2,0.html>, accessed 01 January 2011).

5 Anthony JC, Warner LA, Kessler RC. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: basic findings from the national co-morbidity survey. *Experimental and Clinical Psychopharmacology*, 1994, 2:244–268.

## A. Why harm reduction?<sup>6</sup>

“Harm reduction” refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive and narcotic drugs, without necessarily reducing drug consumption. Harm reduction is an intermediate measure designed to assist those who are unwilling or unable to stop using drugs such as ATS in the short term, ensuring that they do not suffer irreparable long-term harm, thereby benefiting people who use drugs, their families and the community. It is a public health approach that respects human rights and the right to health, and takes out the punitive element from drug “treatment”. To date, the majority of harm reduction services in the Asia–Pacific region has been designed with opioid users in mind, and generally focus on injecting drug users. These efforts have been highly successful in preventing avoidable harms, in particular, averting HIV and hepatitis B and C infections.

ATS users rarely use harm reduction services, largely because they do not identify themselves with opioid users, often belong to different networks of users, and thus do not perceive harm reduction services as relevant to them. The result is that the needs of ATS users are neglected and few services are geared to their special needs.

### A.1 Harm reduction for ATS users

The pattern of ATS use extends from occasional and recreational use to heavy and dependent use (see ATS Brief 1 for more information). The minority of ATS users fall into the problematic/ heavy/ dependent category. The response should thus vary in accordance with the nature and severity of a person’s involvement with ATS. Different interventions are required to address the complexity of ATS use.

#### Steps for developing harm reduction services for ATS users in the community<sup>7</sup>

##### 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

6 International Harm Reduction Association (IHRA). *What is harm reduction? A Position Statement from the International Harm Reduction Association*. London, United Kingdom, 2010. ([http://www.ihra.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf), accessed 01 January 2011).

7 Adapted from World Health Organization. *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings (version 1.0)*. Geneva, WHO Mental Health Gap Action Programme, 2010. ([http://www.who.int/mental\\_health/evidence/mhGAP\\_intervention\\_guide/en/index.html](http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/index.html), accessed 01 January 2011).

In addition, services should provide help with social problems that make lifestyle changes difficult (e.g. homelessness, unemployment, lack of marketable skills, etc.) as well as in dealing with legal problems such as arrests and involuntary incarceration in compulsory centres. Service providers should be ready to arrange medically assisted detoxification and withdrawal support, and refer clients to primary health or specialist medical or psychiatric services if required (e.g. services for voluntary counselling and testing [VCT], and treatment of sexually transmitted infections [STI], tuberculosis and mental health).

## B. Crisis interventions

- *Psychiatric symptoms* such as paranoia, delusions or perceptual disturbances are common among stimulant users. When this occurs, crisis interventions are sometimes indicated. Professional mental health examination and risk assessment should be conducted, and psychiatric treatment provided if required.
- *Withdrawal*: The usual objectives in treating stimulant withdrawal are to assist the user to interrupt a period or pattern of compulsive use, identify and manage co-morbid conditions, and initiate relapse prevention treatment if appropriate. Many users go through the “crash” and “withdrawal” phases and then return to ATS use once again. Those who wish to stop using generally experience the third phase, referred to as “extinction”. Withdrawal from stimulant drugs is not medically dangerous, and no specific pharmacological treatment has been shown to be effective. However, it is recommended that treatment for severe insomnia be provided with light sedatives, and hydration be maintained. It is also important that patients are not physically restrained and are allowed to leave if they so wish, thereby ensuring that treatment is voluntary. Clinicians should be aware that depressive symptoms of varying seriousness may occur both during and after withdrawal, and that there may be a risk of suicide.

The three phases of ATS withdrawal are given in the table below:

Phase	Time since last stimulant use	Common signs and symptoms
“Crash”	Typically commences 12–24 hours after last amphetamine use and subsides by 2–4 days	- Exhaustion, fatigue, agitation and irritability, depression, muscle ache - Sleep disturbances (typically increased sleep, although insomnia or restless sleep may occur)
“Withdrawal”	Typically commences 2–4 days after last use, peaks in severity over 7–10 days and then subsides over 2–4 weeks	- Strong cravings - Fluctuating mood and energy levels, alternating between irritability, restlessness, anxiety and agitation - Fatigue, lack of energy
“Extinction”	Weeks to months  (Requires integration between withdrawal and post-withdrawal services)	- Gradual resumption of normal mood with episodic fluctuations in mood and energy levels, alternating between irritability, restlessness, anxiety, agitation, fatigue, lack of energy - Episodic cravings - Disturbed sleep

## C. Brief interventions

The primary goal of brief interventions targeting ATS users is to engage the person in a discussion about their substance use and steer the discussion towards an evaluation of the positive and negative effects of the substance by challenging overstated claims of benefits. The objective is to encourage the person to decide if they want to change their behaviours.<sup>7</sup> Indeed, brief interventions on their own have been shown to be successful in promoting behaviour change and can often be used as the first stage of more intense treatment if needed.<sup>9</sup>

### C.1 Information and counselling

Counselling is routinely provided to drug users in the community by peer educators/facilitators and outreach workers in harm reduction services. A variety of counselling approaches are used, from client-centred, open-ended counselling<sup>10</sup> to cognitive-behavioural therapy, which is employed by counsellors worldwide. Below is an example of an adaptation of several models for ATS users.

A structured brief counselling model was developed and evaluated in Australia.<sup>11</sup> This approach comprises two to four sessions in which a combination of motivational interviewing and cognitive-behavioural therapy is used. This approach was found to significantly increase abstinence among dependent methamphetamine users after six months. Reduction in amphetamine use was accompanied by significant improvements in stage of change, benzodiazepine use, tobacco smoking, polydrug use, risky injecting behaviour, criminal activity level, and psychiatric distress and depression levels.

At six months of follow up, close to half of the treatment groups were abstinent compared with only 30% of those who received a self-help booklet based on similar information. This study concluded that this approach was an effective first step in providing interventions to ATS users.

In addition, harm reduction services should include, wherever possible, self-help groups for users and families, vocational and skills training, employment or educational services, legal and housing support, etc.

9 National Drug Research Institute. *National Stimulant Strategy Background paper: monograph series No.69. 5.5. Psychosocial interventions*. Australian Government, Department of Health and Ageing, 2007:68. ([http://www.health.gov.au/internet/drugstrategy/Publishing.nsf/content/98CFCAEC1A10BE00CA2574C5000C2641/\\$File/mono69.pdf](http://www.health.gov.au/internet/drugstrategy/Publishing.nsf/content/98CFCAEC1A10BE00CA2574C5000C2641/$File/mono69.pdf), accessed 01 January 2011).

10 Rogers C. *Client-centred therapy: its current practice, implications and theory*. Boston, Houghton Mifflin, 1951.

11 Baker A et al. Brief cognitive behavioural Interventions for regular amphetamine users: a step in the right direction. *Addiction*, 2005, 100:367–378

## D. Meeting the challenges of harm reduction directed at ATS users<sup>12</sup>

Many factors contribute to drug-related risks and harms. These include the behaviour and choices of the individual drug user, the environment in which they use drugs, and the laws and policies designed to control drug use. Many policies and practices, intentionally or unintentionally, create and exacerbate the risks and harms for drug users. These include the criminalization of drug use, discrimination, abusive and corrupt policing practices, restrictive and punitive laws and policies, denial of life-saving medical care and harm reduction services, and social inequities. Policies and practices must support individuals in changing their behaviour.<sup>13</sup>

To date, harm reduction services are focused on injecting drug users, especially opioid users. However, the problems presented by ATS users require an expansion and adaptation of these services. The challenges include the ease with which amphetamines are obtained, coupled with a lack of sufficient understanding of the special needs of ATS users and an unwarranted pessimism about interventions targeting ATS users. Policy-makers must aim to reduce the harms from ineffective drug policies which allow for undifferentiated punishment and detention of all drug users, and find common ground between law enforcement and public health, thus enabling appropriate interventions to assist all ATS users.

12 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The fast and furious: cocaine, amphetamines and harm reduction. In: *Harm reduction: evidence, impacts and challenges*. Lisbon, EMCDDA, 2010:191–232 (Monograph 10). (<http://www.emcdda.europa.eu/publications/monographs/harm-reduction>, accessed on 31 December 2010).

13 International Harm Reduction Association (IHRA). *What is harm reduction? A Position Statement from the International Harm reduction Association*. London, United Kingdom, IHRA, 2010:p.2.

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