

Amphetamine Type Stimulants and Harm Reduction

Experiences from Myanmar, Thailand and Southern China

By Tom Blickman¹

Problematic use of amphetamine-type stimulants (ATS)² has become a significant health and social problem in East and Southeast Asia, in particular the use of methamphetamine, the most potent amphetamine derivative and most widely used substance in the region. According to the United Nations Office on Drugs and Crime (UNODC), East and Southeast Asia have one of the most established methamphetamine markets in the world displacing traditionally plant-based drugs such as heroin, opium and cannabis.³

ATS use is associated with a range of communicable diseases such as HIV, hepatitis B and C infections and other sexually transmitted infections (STI), tuberculosis and mental health problems, in particular among vulnerable groups such as female sex workers and other workers in the entertainment/hospitality industry (clubs and casinos); youth (specifically among homeless, unemployed and incarcerated youth), and migrants. There is an urgent need to scale up prevention, treatment and harm reduction services in the region to avoid the further spread of these potentially life-threatening infections.

Little is known about the methamphetamine market in the region. Prevention, treatment as well as harm reduction⁴ strategies are in their initial phases. There are strong indications that the situation is deteriorating: the substances are becoming stronger (from pills to crystal methamphetamine or 'ice') and methods of use are becoming more harmful (from swallowing pills to

KEY POINTS

- Problematic use ATS has become a significant health and social problem in East and Southeast Asia. ATS use is associated with potentially life-threatening communicable diseases in particular among vulnerable groups such as female sex workers, youth and migrants.
- Incarceration of ATS users in compulsory drug treatment/detention centres is ineffective. There is evidence of serious human rights abuses and relapse rates are extremely high upon release. Community-based interventions based on prevention, early intervention, harm reduction and treatment offer a more effective and humane alternative.
- Prevention, treatment and harm reduction strategies are in their initial phases. There is a lack of professional expertise and counselling training, and little experience in dealing with the psychosocial and mental health problems. There is a need to develop effective prevention, treatment and harm reduction measures that fit the cultural and socio-economic circumstances in the region.
- There is an urgent need for donors and governments to introduce harm reduction measures to counter the effects of rising methamphetamine use. Services are still focused on injecting heroin users as the main problem and have little to offer for ATS users. The earlier a comprehensive package of harm reduction measures for methamphetamine is introduced the better.
- More research is needed to understand ATS market and user trends, the negative impacts of law enforcement interventions on levels and patterns of use, as well as the chemical composition of the substances.

injecting), and the number of ATS users – especially among youth – keeps increasing. In this briefing we will try to give an overview of the situation with a special focus on Burma/Myanmar,⁵ while taking into account the context in neighbouring countries.

Law enforcement and supply reduction approaches currently dominate the response to ATS use in the region. These approaches frequently result in unintended negative consequences. One of these consequences has been a proliferation of trafficking routes and expansion of the market, the so-called ‘balloon effect’ of interdiction. Evidence suggests that use increases along new trafficking routes. Thailand’s 2003 ‘war on drugs’ led to increased border surveillance and a move of direct trafficking routes from Burma to Thailand to more indirect routes over the Mekong river via Laos and Cambodia, resulting in an increase of methamphetamine use in those countries.

Another negative consequence of the zero-tolerance law enforcement approach is the widespread incarceration of ATS users in compulsory drug treatment/detention centres (CDTDCs) whose treatment goal is abstinence. Although it is the most prominent intervention in the region there is no evidence of effectiveness. All the evidence suggests that relapse rates are extremely high upon release from the CDTDCs. There is also mounting evidence of human rights abuses in these facilities.⁶ The vast majority of users are, in fact, not problematic and compulsory treatment risks creating problems where there are none.

Treatment and harm reduction in Southeast and East Asia mainly focuses on heroin, opium and cannabis users. Although the majority of countries in the region have embraced harm reduction as a legitimate drug treatment, harm reduction services that target ATS users are inadequate. Most harm reduction services have been designed for opioid users, and generally focus on injecting drug users. These efforts have

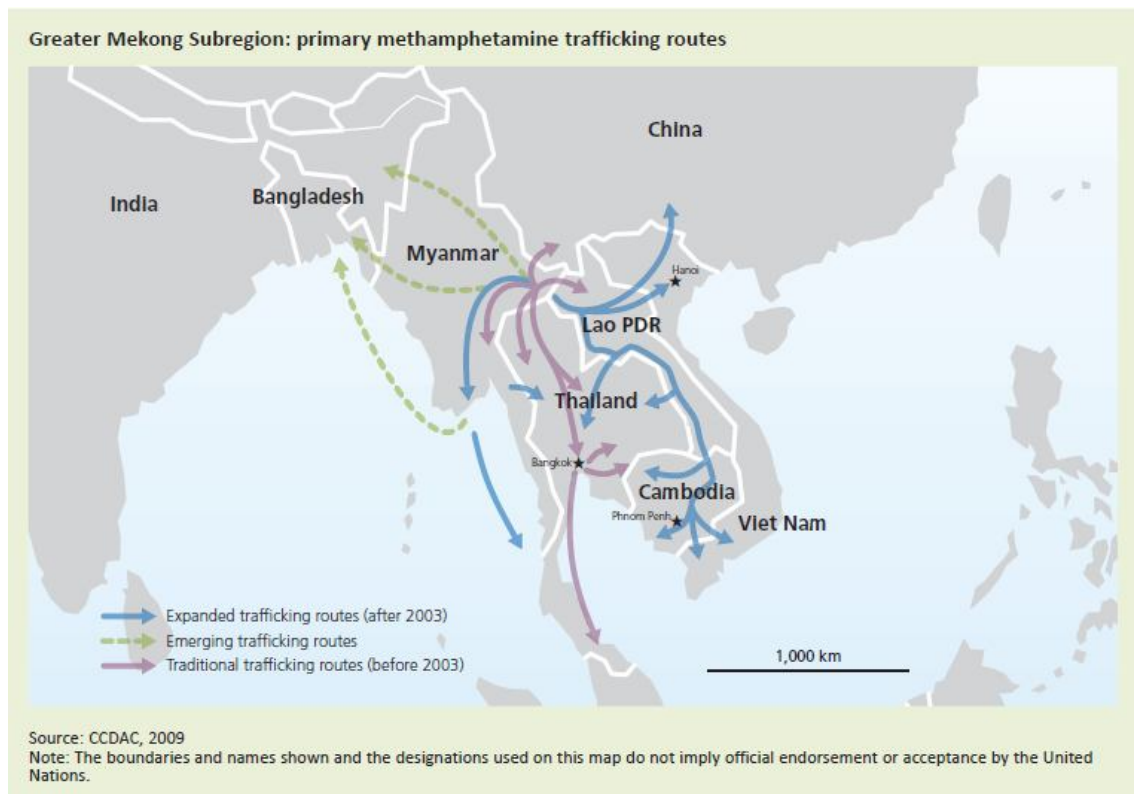
been highly successful in preventing avoidable harms, in particular, averting HIV and hepatitis B and C infections. Some of these measures are useful for problematic methamphetamine use (in particular in the case of injecting drug use), but do not cover the whole range of specific problems associated with problematic methamphetamine use.

ATS users rarely use harm reduction services, largely because they do not identify with opioid users, who often belong to different user networks. Most ATS users do not perceive harm reduction services as relevant to them. The needs of ATS users are usually neglected and few services are geared to their special needs.⁷ The development, evaluation and expansion of harm reduction interventions specific to amphetamines, should be the first priority for the international harm reduction community, according to the Global State of Harm Reduction report of 2010.⁸

ATS harm reduction programmes have shown positive results in some countries. However, these programmes are limited to Australia and North America. As the effectiveness of pharmacological and psychosocial interventions for stimulant users is limited, interventions to stabilise and minimise the negative consequences of ongoing methamphetamine use are of paramount importance. A wide range of health and social problems associated with stimulant use are largely unaddressed by current services.⁹ According to the World Health Organization Regional Office for the Western Pacific there is a lack of professional expertise and counselling training in the region, and little experience in dealing with the psychosocial and mental health problems of ATS users. Consequently, there is a need to develop harm reduction measures that fit the cultural and socio-economic circumstances in Southeast and East Asia.

ATS IN SOUTH-EAST ASIA AND CHINA

In East and Southeast Asia the main type of ATS is methamphetamine in the form of



tablets, popularly known as *yaba* ('crazy-medicine') or *yama* ('horse-medicine') pills in Burma and Thailand; and as *ma-huang-su* in China. High purity crystal methamphetamine or 'ice' (rock-like crystals resembling frozen water; *ya ice* in Thailand, or *bingdu* in China) is increasingly popular in the region.¹⁰ Less common are ecstasy type ATS or psychedelic amphetamines (*ya-E* in Thailand; *yao-tou-wan* or 'head-shaking pills' in China).

Ecstasy type ATS in the region is most likely methamphetamine mixed with ketamine with little if any MDMA ('real ecstasy' primarily produced in Europe), or else MDMA imported from Europe mixed with caffeine, heroin or ketamine in labs in China. A third popular substance is ketamine (*ya-K* in Myanmar and Thailand; *k-feng* or 'k-powder' in China), which is an anaesthetic that has hallucinatory effects and is also used in pure form.¹¹

According to the *2011 Global ATS Assessment* by the UNODC, the Greater Mekong Subregion, which includes Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand, Vietnam and bordering

provinces of southern China, is seriously affected by the production, trafficking and use of methamphetamine on a large scale. Whereas previously Burma, the bordering provinces of southern China and Thailand have been most impacted by ATS, the problem has shifted over the past years to Cambodia, the Lao People's Democratic Republic and Vietnam, due to shifting patterns of trafficking routes throughout the region.

The ATS boom in the region is an example of what can be described as 'displacement': a campaign against one drug (opium and heroin) can lead to the rise of an equally or potentially even more harmful substitute (methamphetamine). International pressure and national opium eradication campaigns led to a decline in opium cultivation and heroin production in the Golden Triangle. At the same time, a methamphetamine market in East and Southeast Asia developed, and resulted in the rise of manufacturing facilities in what was traditionally an opium and heroin area.

Adding to the displacement were rising opiate prices. The surrender of Khun Sa

and his Mong Tai Army (MTA) in 1996, the largest player in the Burmese opium market, disrupted the regional heroin trade and caused price instability. The MTA had begun production of and trade in ATS in the early 1990s. MTA breakaway groups also became heavily involved in large-scale methamphetamine production, flooding the Thai market.

According to the UNODC, Burma “remains the major source of methamphetamine pills in the Greater Mekong Sub-region. Most illicit methamphetamine manufacture takes place in the eastern part of Shan State. Forensic profiling of ATS in Thailand suggests there are at least 12 methamphetamine manufacturing sites in Myanmar. In addition, there are indications that at least 50 different organized criminal groups are involved in activities related to the trafficking of drugs from Myanmar.”¹²

While the reduction in the availability of opium and heroin during the mid- to late 1990s resulted in opiate users shifting to methamphetamine, this alone cannot account for the significant increase of ATS. Although there is some overlap and interaction in opiate and methamphetamine use, the methamphetamine market has its own distinct dynamics.

By 2006, the trend of a declining opium market and an increasing ATS market was apparent in all countries in Southeast Asia. Although China, Burma and Vietnam still list opium and heroin as their main problem, Cambodia, Laos, and Thailand cited methamphetamine as the leading drug of concern. China, however, stated that consumption in pill and crystal form was still increasing. Thailand reported that use of crystal methamphetamine had increased, but use of *yaba* was on the decline. Laos and Thailand ranked *yaba* as their primary drug of concern with only Laos reporting an increase in heroin too. Burma and China still listed heroin first, both reporting a decrease in its use.¹³

The increase in the use of methamphetamine and other ATS has been driven by both demand and supply, as well as profound socio-economic changes in the countries affected, which have moved from rural agricultural based economies to urban, industrial and market based societies. ATS appeal to what is perceived to be a modern lifestyle, both recreationally and occupationally. Stimulants fit better in the new competitive and industrious cultures of rising economies in Southeast and East Asia (Japan in the 1950s, South Korea and Taiwan in the 1970s and then Thailand and China) and the changes in work habits and work pace.

Methamphetamines give ambitious, upwardly mobile, urban people the energy to succeed and the urban and rural labour forces a necessary stimulant to work more and longer hours needed in competitive economies with poor labour conditions. Methamphetamine helps labourers endure backbreaking work in the fields and allows affluent urbanites to party till dawn.

The rise of ATS also reflects generational differences and fashions of drug use. Opium and heroin use are associated with older generations. Opium is perceived as a substance for ‘old people’ and ‘backward hill tribes’, while heroin is perceived as a drug for losers. ATS on the other hand has a social acceptance, particularly among young Asians. ATS are becoming popular among urban youth and are consumed in entertainment facilities, such as bars, karaoke clubs, and nightclubs. ATS are considered to be non-habit forming and more ‘fun’ to use, while opium and heroin are considered a thing of the past, and seen as dangerous and addictive.

TRENDS IN USE IN THAILAND, BURMA AND YUNNAN

The main trends regarding use patterns are a shift from opiates (opium/heroin) to ATS and a shift from work-related use of methamphetamine to recreational use. Substan-

ces are getting stronger (from *yaba* pills to 'ice' or crystal methamphetamine) and methods of use are getting more harmful: from swallowing pills to smoking ('chasing the dragon') to injecting.

In 2003, Thailand's Academic Substance Abuse Network estimated that 3,500,000 citizens between the ages of 15 and 60 had ever used methamphetamine in tablet form. A second survey in 2003, suggested that approximately 1 million people in Thailand had used methamphetamine in the previous year. Of the 450,000 people who reported using methamphetamine within the last 30 days, 73 percent were between 12 and 24 years old.¹⁴

In 2009, 82% of all drug users in Thailand, who received drug treatment, were treated for methamphetamine pill use.¹⁵ 'Ice' was introduced to Thailand a few years ago and is rapidly expanding to all of the country. Recent research by the Thai Office of the Narcotics Control Board (ONCB) indicates that crystal methamphetamine is the most popular drug among addicts, half of them aged between 15 and 24 years old.¹⁶

In Burma very little research or surveys have been carried out, but anecdotal evidence suggests that methamphetamine use is on the rise. At an informal expert seminar on ATS and harm reduction in Kunming (Yunnan, China), in November 2010, Burmese user groups and outreach workers said that the younger generation prefers ATS over heroin. ATS use has been recorded for more than ten years and the generation which is now around 25 years old is probably the last one that used heroin. They emphasised the urgent need for better surveys to improve the limited data available concerning ATS market trends, the number of users, and treatment and relapse, as well as a scale up of awareness raising programmes, and improved targeting of current users.

Average *yaba* use in Burma is around 3-4 tablets per day (drug users say that when

you use only two tablets "you don't get high you get lost"), mid-level usage is 10 per day, and high usage is more than 20-30 tablets per day. Tablets are inhaled, smoked, injected and ingested. ATS is used in nightclubs and entertainment venues. Staff in these venues also tends to use and often act as middle men for dealers and receive commission. In night clubs and among commercial sex workers ATS is used to get stamina. There is also work-related use among truck drivers and sailors etc., as well as motorcycle traffickers at the borders. Mining areas also have high prevalence of drug use but not necessarily methamphetamine.

The use of methamphetamine among students is alarming – especially at high school age. ATS is seen as cool. Young people tend to use ATS in groups and at funerals and weddings when people often use to stay up all night during ceremonies. *Yaba* is at times provided by the hosts at these gatherings. Methamphetamine use is easier to hide than other types of drug use, and parents are often unaware. Users mix methamphetamine with alcohol because this helps them to sleep. There is no preventive education, and often young users do not know their limits.

China is seeing an increase in the use of crystal methamphetamine, according to an annual drug abuse monitoring report released by the country's State Food and Drug Administration (SFDA) in April 2011. The use of other drugs, such as heroin, has decreased over time. Heroin and crystal methamphetamine were still the two most widely-used illegal drugs.

Illegal activity related to the use of crystal methamphetamine and ketamine has increased in recent years. The report stated that police seized more crystal methamphetamine than heroin in 16 of China's 31 provincial-level regions last year. Police records showed that China had 432,000 ATS users by the end of 2010, accounting for 28 percent of the country's registered 1.5 mil-

lion drug users in 2010 (up from 560,000 registered users in 1995).¹⁷ Last year saw 118,000 more ATS users than 2009.¹⁸

However, this figure only reflects the tip of the iceberg as most users are not registered, both because of stigmatisation and the punitive measures adopted by the Chinese authorities against drug users. Unofficially, Chinese officials estimate the actual figure to be higher than five million and in some more pessimistic assessments up to 15 million. In 2006, Chinese official sources put the figure at 4 million as a guesstimate.¹⁹ ATS are the preferred illegal substance of choice for youngsters as part of the growing rave culture that has established itself in all major Chinese cities. The new population of ATS users does not appear on the Chinese radar-screen, as official Chinese statistics have focused on the heroin users.²⁰

In Yunnan province in Southwest China bordering Burma, Laos, and Vietnam, the situation is different to the large cities in the East of China, but closer to the situation in the neighbouring countries. Methamphetamine tablets are the ATS of choice in Yunnan, while in the northeast and southeast the crystal form is more popular. Whether crystal methamphetamine from labs in East China is entering Yunnan and onward to the Greater Mekong Subregion is unclear. However, crackdowns on the production of crystal methamphetamine in East China might result in a displacement of production to the Greater Mekong Subregion and Burma in particular, where enforcement is difficult due to the complicated situation with ethnic minority groups.

Outreach workers in Kunming told TNI researchers that the police generally do not arrest ATS users but only impose fines (300 Yuan/45 USD). Police do not enter ATS offences into their surveillance databases. Heroin users are much more stigmatised and risk arrest and prison or compulsory detoxification for two years. With new drugs like ATS there is no addiction in the

legal sense, but users can be fined. Instead of detoxification, ATS users pay the fine and there is no other punishment. However, emergency room doctors report major issues with problematic ATS use by young men, in particular high levels of aggression among ATS users.²¹

The trend in Yunnan is that drug use is shifting from traditional opium to heroin and now ATS, mainly *yaba*. According to a peer educator there are more ATS users than traditional opium and heroin users in Yunnan nowadays. There are many negative health effects, but there is hardly any research on ATS and drug use trends.

In Yunnan, methamphetamine pills are mostly smoked, injection is rare. In villages near the border with Myanmar there is a lot of methamphetamine use. At weddings and funerals young people come together and use *yaba*, creating peer pressure to participate. Some users also use heroin to calm down after ATS use. They combine methamphetamine with heroin and this mixture is smoked.

There is limited research about polydrug use among drug users in Yunnan. One research project wanted to understand ATS use among methadone maintenance treatment (MMT) clients and help to improve services in 68 MMT clinics in Yunnan. Research in 2008 among 1935 clients from 12 counties in Yunnan Province showed that 27.9% tested positive for heroin and 12.4% tested positive for methamphetamine. During a three month period of urine testing, 42% had used methamphetamine more than three times.

The younger generation is using ATS in different settings, and unlike heroin users they are not as marginalised in society and are not seen as a nuisance. By and large, the risks of ATS use are underestimated and users feel that ATS is not addictive. Tablets are available in many colours and with different logos; prices vary a lot from 16 to 40 Yuan per tablet (2.5- 6 USD).

PATTERNS OF USE

The growing use of ATS is associated with the spread of HIV and hepatitis in diverse segments of the population, largely due to an increase in risk-taking behaviour and unsafe sex practices among users. There are also high rates of self-reported depression and alcohol consumption, and psychosis. According to the WHO, the public perceptions of the risks of ATS use are both underestimated and overestimated. Attempts to totally eliminate the problem by stringent law enforcement and compulsory treatment can be seen as an example of over-reaction – where even modest occasional use is regarded as dangerous and criminal. In contrast, others argue that recreational use is harmless, and that users will discontinue themselves without needing outside intervention. The truth, according to the WHO, lies somewhere in the middle.

It is important to stress that not every user turns into a problematic user; the majority, in fact, do not.²² The vast majority of users are either experimental or ‘recreational’ users who use drugs occasionally on weekends or at parties, or irregular or ‘binge’ users who use a lot for a few days consecutively but not regularly or consistently. Research in Australia estimated that only a minority, around 3% of methamphetamine users, can be characterized as regular users. Other research indicates that the number of dependent users that require specialist interventions is larger and estimated at around 11%.²³

However, even occasional nondependent users may experience physical, social or psychological harm from their use, and may progress to more harmful or intensive drug use. They would benefit from harm reduction interventions designed to moderate the potential harm from their ATS use and associated lifestyle. Compulsory treatment of those kinds of users in closed centres is counterproductive and stigmatising, and will only increase problems in the vast majority of cases. Overall, the picture is of

lots of different people, using lots of different forms of methamphetamine, in lots of different ways, for many diverse reasons. Without an understanding of how use fits into an individual’s life, of what function the substance serves, it is impossible to offer credible or useful advice.²⁴

People use methamphetamine for different reasons. The substance is attractive to users because it is perceived as enhancing performance, including sexual performance, and communication and, in some circles, has come to embody a modern and fashionable lifestyle. Consumers usually start off using because it makes them feel good. Use is often initiated in ‘convenient’ and discrete pill form, avoiding the dangers and social stigma of injection or smoking. They are affordable, often sold in single tablet units.

People say methamphetamine boosts their confidence, self-esteem, concentration, energy and can help with work or study and sexual pleasure. Despite these positive effects, regular users often begin to experience things like paranoia, aggression, hallucinations, lack of sleep, loss of weight, dependence and a general decrease in health and wellbeing. These may be understood as side effects of an over-stimulated or exhausted nervous system. The effects of methamphetamine on brain chemistry (especially on dopamine regulation), combined with malnutrition, sleep deprivation, and dehydration typically associated with regular stimulant use, can provoke these sorts of problems in otherwise healthy individuals.

Methamphetamine users range from occasional/recreational use to heavy, problematic injecting and polydrug use. It can be ingested (swallowed), snorted or smoked and, less commonly, injected. In powder form, methamphetamine is generally swallowed or snorted. The crystalline form of methamphetamine, ‘ice’, is typically smoked. When smoked or injected, ‘ice’ reaches the brain rapidly and is associated

with a high risk of dependence. Growing evidence indicates that smoking crystal methamphetamine has more harmful psychological effects and a higher addictive potential than other forms of methamphetamine.²⁵ Long-term use of ATS can result in dopamine²⁶ reduction, which can cause severe mood disorders as well as paranoia, violent behaviour, depression, psychosis, and cardiopulmonary damage.

Polydrug use is very common among methamphetamine users. Alcohol or cannabis are often used to reduce undesired overstimulation. The combination of alcohol and methamphetamine increases the risk of risky sexual behaviour and an increase of sexually transmitted infections (STI). Other harms among users include mental illnesses such as methamphetamine psychosis, alcohol dependence and depression.

RESPONSES

Despite the increase of ATS use and associated problems, government responses in East and Southeast Asia have been ineffective. Traditional law enforcement and supply reduction approaches and zero tolerance attitudes have not succeeded to reduce the supply and the demand for ATS. One might even argue that the unintended negative consequences of ill-designed law enforcement interventions and zero-tolerance policies have exacerbated the problems.

Many factors contribute to ATS related risks and harms. Not only the substance, but also the behaviour and choices of the individual user, the environment in which they use ATS, and the laws and policies designed to control drug use. Many policies and practices unintentionally create and exacerbate the risks and harms for users including the criminalisation of 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.

There are some promising indications in the region of a willingness to embark on new approaches, at least on paper. The Sub-Regional Action Plan on Drug Control 2011-2013, agreed upon by the countries in the Greater Mekong Subregion and the UNODC, recognises that “while there are internationally tested drug prevention approaches and psychosocial interventions for ATS use and dependence, these have not yet been fully validated in Southeast Asia, where ATS use is on an upward trend and represents a majority of treatment demand in several countries in the region.” The Action Plan recognises the need to scale up public health oriented policies, as well as the need to develop alternatives to CDTDCs and implementation of community-based interventions based on prevention, early intervention, treatment and care programmes integrated in the health care system.²⁷

The WHO Regional Office for the Western Pacific recommends that “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.”²⁸ The office published a series of four technical briefings laying out the latest available evidence on patterns and consequences of ATS use; harm reduction and brief intervention; guiding principles of prevention and treatment; and therapeutic interventions.²⁹

Since the pattern of ATS use extends from occasional and recreational use to heavy and dependent use, and only a minority of ATS users fall into the problematic category, the response should 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.

According to the WHO, services should also provide help with social problems that

make lifestyle changes difficult (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 arrange medically assisted detoxification and withdrawal support, and refer clients to primary health or specialist medical or psychiatric services if required, such as services for voluntary counselling and testing (VCT), and treatment of sexually transmitted infections (STI), tuberculosis and mental health.³⁰

At the 2010 ATS and Harm Reduction expert seminar, drug user groups and outreach workers from Burma, Thailand and Yunnan formulated a series of possible strategies to try to start tackling the situation:

Advocacy and awareness raising

- Governments, donors, and users still are not fully aware of the problems associated with ATS use, and the rapid increase of ATS use among youth in particular. Awareness raising has to start at the 'user level'. User organisations and NGOs need to raise the issue with donors and multilateral agencies. More advocacy is needed to educate policy makers, law enforcement, health care providers, donor agencies, civil society and community on ATS and effective and humane responses.
- The scale of ATS use is unknown. Currently, all data is based on information in heroin injecting drug use but the picture for ATS use could be quite different. More research and data are needed on ATS market trends, ATS use, patterns of use and harmful practices. A survey on use and patterns of use is needed. Simple anonymous questionnaires to capture data on prices and availability, risky behaviours and measures to prevent them, as well as possible self-help strategies, should be developed for drug user groups and outreach workers to fill the information gap. However, research permission has to be applied for from the

Burmese government, and this is a barrier to getting the data needed.

- Best practice exchange and capacity building among self-help groups, outreach workers and health and harm reduction associations. Evidence based educational resources with experiences from other countries need to be translated into local languages and adapted to the local and cultural context to make them relevant and to support peer outreach.
- The distinction between heroin and ATS users has become blurred in Australia as well as other countries in the region and many injectors are polydrug users, using methamphetamines and heroin. In Burma, there is also polydrug use of pharmaceuticals and raw opium mixed with cough syrup, called 'formular'. More research on use patterns is necessary to detect new trends at an earlier stage in order improve proper responses.
- Awareness raising with drug users on how to use more safely is necessary. In particular with vulnerable groups (youth, migrants and sex workers) to educate them of the risks and possible harms of ATS use. Awareness on sexual transmission of HIV and HCV in relation to ATS use needs to be increased. In addition to unsafe injecting, risky sexual practices that often accompany ATS use can also lead to the spread of blood borne viruses and are possibly even more unsafe. Commercial sex workers in particular urgently need self help strategies and harm reduction information for ATS use.
- A major concern is not to criminalise ATS users in awareness raising campaigns and advocacy towards donors and government agencies.
- Don't get trapped in a 'one size fits all approach'. There is a need to differentiate between drug use patterns, per country epidemiology and cultural sensitive approaches to reach users. Targeted interventions for specific groups of users are

essential, such as injectors and non-injectors, youth, women, minorities, sex workers, etc.

Treatment and harm reduction services

- Exchange of experiences in treatment and harm reduction measures were recommended. There are some quite simple measures on personal hygiene and nutrition that could be introduced easily at low costs, such as making water and fruits available at low threshold drop-in centres (DICs) as well as toothpaste and brushes. Information on how to improve diets, get adequate rest, strategies to help control drug intake and monitor behaviours should be available as well. 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 blood borne diseases from shared contaminated equipment. These measures are inexpensive and can make an enormous difference.
- Preventive measures should be enacted such as discouraging injection, distributing condoms and lubricants, needle and syringe exchange programmes (NSEP), and providing of information, education and communication (IEC) materials for drug users, their sexual partners and their families. UNAIDS and WHO need to bring attention to this issue particularly looking at the increased sexual risk through non-injected ATS use.
- Psycho-social support needs to be strengthened by expanding voluntary counselling and testing (VCT), nutrition support and ATS counselling. Experience in Thailand has shown that developing psychosocial and peer-based intervention and peer driven activities, – as well as youth-centred and community-based harm reduction programmes – can be more sustainable and more effective than compulsory CDTDCs. Users of the same age need to reach out to other users; this will have greater impact. Engaging educational

materials for clients are needed, such as short films. Ensuring community participation in the planning stage of programmes is important. Programmes should include harm reduction strategies and approaches and introduce these into the communities where primary prevention programmes are being implemented.

- Establishing links and a referral network to health and welfare facilities. Health care measures should include primary health care, STI diagnosis and treatment, psychosocial support and personal hygiene. STI clinics and condom distribution programmes are good entry points for reaching methamphetamine users. Drug education should be integrated with condom distribution.
- Prescription of oral doses of sustained-release dexamphetamine might help with getting people off methamphetamine (just like giving nicotine to people who are trying to stop smoking).³¹ Dexamphetamine substitute treatment for amphetamine dependence shows promising results and appears to be effective and safe in particular in preventing relapse. But research has been much more limited than for methadone treatment for heroin users.³² Possible use of mild plant-based stimulants as substitution treatment (kratom³³ in Thailand and Burma; ephedra in China) should be evaluated as well.

NOTES

1. Tom Blickman is a senior researcher with the Transnational Institute (TNI). This briefing draws on the outcomes of the Expert Seminar on ATS and Harm Reduction on November 26-27, 2010, in Kunming (Yunnan, China), organised by TNI with the support of the Western Australian Substance Users Association (WASUA).

2. The World Health Organisation (WHO) defines amphetamine-type stimulants (ATS) as a group of drugs whose principal members include amphetamine and methamphetamine. However, a range of other substances also fall into this group, such as methcathinone, fenetylline, ephedrine, pseudoephedrine, methylphenidate and MDMA or 'ecstasy' – an amphetamine-type derivative with hallucinogenic

- properties.
http://www.who.int/substance_abuse/facts/ATS/en/index.html
3. *2011 Global ATS Assessment*, United Nations Office on Drugs and Crime (UNODC), August 2011; http://www.unodc.org/documents/ATS/ATS_Global_Assessment_2011.pdf
 4. Harm reduction refers to policies and practices aimed to reduce adverse health and social consequences for drug users, their families and society as a whole, without necessarily ending drug consumption.
 5. In 1989 the military government changed the official name from Burma to Myanmar. They are alternative forms in the Burmese language, but their use has become a politicised issue. Myanmar is not commonly used in the English language. Burma is also used in this report. This is not intended as a political statement.
 6. 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)
 7. *Technical Brief 2: Harm reduction and brief intervention for ATS users*, Technical Briefs on amphetamine-type stimulants (ATS), World Health Organization, Regional Office for the Western Pacific; <http://www.wpro.who.int/sites/hsi/documents/atstechnicalbriefs.htm>
 8. *Speeding up the response: A global review of the harm reduction response to amphetamines*, by Sophie Pinkham, in the *Global State of Harm Reduction 2010*, International Harm Reduction Association, 2010.
 9. *The fast and furious – cocaine, amphetamines and harm reduction*, in *Harm reduction: evidence, impacts and challenges*, EMCDDA, Lisbon, April 2010.
 10. For more background, see the chapter ‘The ATS Boom in Southeast Asia’ in *Withdrawal Symptoms in the Golden Triangle: A Drugs Market in Disarray*, Tom Kramer, Martin Jelsma and Tom Blickman, Transnational Institute, January 2009 at <http://www.tni.org/report/withdrawal-symptoms-golden-triangle-4> (including Chinese and Burmese versions of the conclusions and recommendations).
 11. In fact ketamine does not really belong to ATS group, but its hallucinatory effects, mixture with methamphetamine, and use in the same set and setting makes it a related substance.
 12. ‘ATS Situation in Thailand’, Thailand Office of the Narcotics Control Board, presented at the Global SMART Programme Regional Workshop, Bangkok, July 2009.
 13. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs: Asia and the Pacific 2006*, United Nations Office on Drugs and Crime, June 2007.
 14. *Detention of methamphetamine users in Cambodia, Laos and Thailand*, op. cit.
 15. *Patterns and Trends of Amphetamine-Type Stimulants and Other Drugs: Asia and the Pacific 2010*, Global SMART Programme, United Nations Office on Drugs and Crime, November 2010; http://www.unodc.org/documents/eastasiaandpacific//2010/11/ats-2010-report-launch/ATS_Report_2010_web.pdf
 16. ‘Ice’ becomes drug of choice among young, The Bangkok Post, September 9, 2011
 17. *China’s War on Narcotics: Two Perspectives*, by Niklas Swanström & Yin He, Silk Road Paper - Central Asia-Caucasus Institute & Silk Road Studies Program, December 2006 <http://www.silkroadstudies.org/new/docs/Silkroadpapers/2006/0612PRCNarcotics.pdf>
 18. *China sees rising synthetic drug abuse: report*, People’s Daily, May 19, 2011
 19. *China’s War on Narcotics*, op. cit.
 20. *China’s War on Narcotics*, op. cit.
 21. ‘The ATS Boom in Southeast Asia’, op. cit.; personal information at ‘ATS and Harm Reduction: Experiences from China, Myanmar and Thailand’, TNI seminar in Kunming, November 26-27, 2010
 22. *Technical Brief 2: Harm reduction and brief intervention for ATS users*, op. cit.
 23. *Technical Brief 2: Harm reduction and brief intervention for ATS users*, op. cit.
 24. *Everything You Ever Wanted To Know About Methamphetamine, (but were too paranoid to ask)*, by Paul Dessauer, Outreach Coordinator of the Western Australian Substance Users’ Association (WASUA); <http://www.wasua.com.au/>
 25. *Technical Brief 1: Patterns and consequences of the use of amphetamine-type stimulants*, Technical Briefs on amphetamine-type stimulants (ATS), World Health Organization, Regional Office for the Western Pacific; <http://www.wpro.who.int/sites/hsi/documents/atstechnicalbriefs.htm>
 26. Dopamine is the “reward neurotransmitter” that is highly active in numerous reward pathways of the brain. Various studies have shown that in select regions, amphetamine increases the concentrations of dopamine. This specific action hints at the hedonic response to the drug as well as to the drug’s addictive quality.
 27. *Sub-Regional Action Plan On Drug Control 2011-2013*, United Nations Office on Drugs and Crime (UNODC), May 2011.
 28. *Technical Brief 2: Harm reduction and brief intervention for ATS users*, op. cit.

29. *Technical Briefs on amphetamine-type stimulants (ATS)*, World Health Organization, Regional Office for the Western Pacific; available at <http://www.wpro.who.int/sites/hsi/documents/atstechnicalbriefs.htm>

30. *Technical Brief 2: Harm reduction and brief intervention for ATS users*, op. cit.

31. Dexamphetamine and Ritalin are medications used to treat Attention Deficit Disorder (ADD). A legal form of methamphetamine (Adderall) is prescribed to treat ADD, narcolepsy, and obesity. Modafinil (marketed under the name "Provigil"), a mild non-amphetamine stimulant originally approved as a medication for narcolepsy, is also being tested as a potential treatment in methamphetamine addiction. In the United Kingdom dexamphetamine is used to treat stimulant abuse. In a 2001 study, researchers found that prescribing dexamphetamine decreased their clients' consumption of street methamphetamine and amphetamine and reduced the frequency of intravenous drug use. The UK's Department of Health recommends limited prescription of dexamphetamine to patients who use street amphetamine in order to reduce craving, minimize withdrawal, and stabilize them as part of drug treatment. British doctors prescribe dexamphetamine to amphetamine

abusers on an ongoing basis to reduce criminality and legal problems, discourage injection drug use and improve the health of their patients. See: *Substitution therapy for amphetamine users*, by James Shearer, John Sherman, Alex Wodak & Ingrid Van Beek, *Drug and Alcohol Review* (2002) 21, 179-185.

32. *Demand reduction and harm reduction*, by Alex Wodak, Working Paper prepared for the First Meeting of the Global Commission on Drugs Policy, Geneva, 24-25 January 2011; http://www.globalcommissionondrugs.org/Arquivos/Global_Com_Alex_Wodak.pdf

33. Kratom is attracting increasing attention as a natural alternative to medically supervised opioid substitution therapy (OST) because of its capacity to attenuate potentially severe withdrawal symptoms. See: *Kratom in Thailand: Decriminalisation and Community Control?* by Pascal Tanguay, Series on Legislative Reform of Drug Policies Nr. 13, April 2011; <http://www.druglawreform.info/images/stories/documents/dlr13.pdf>

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