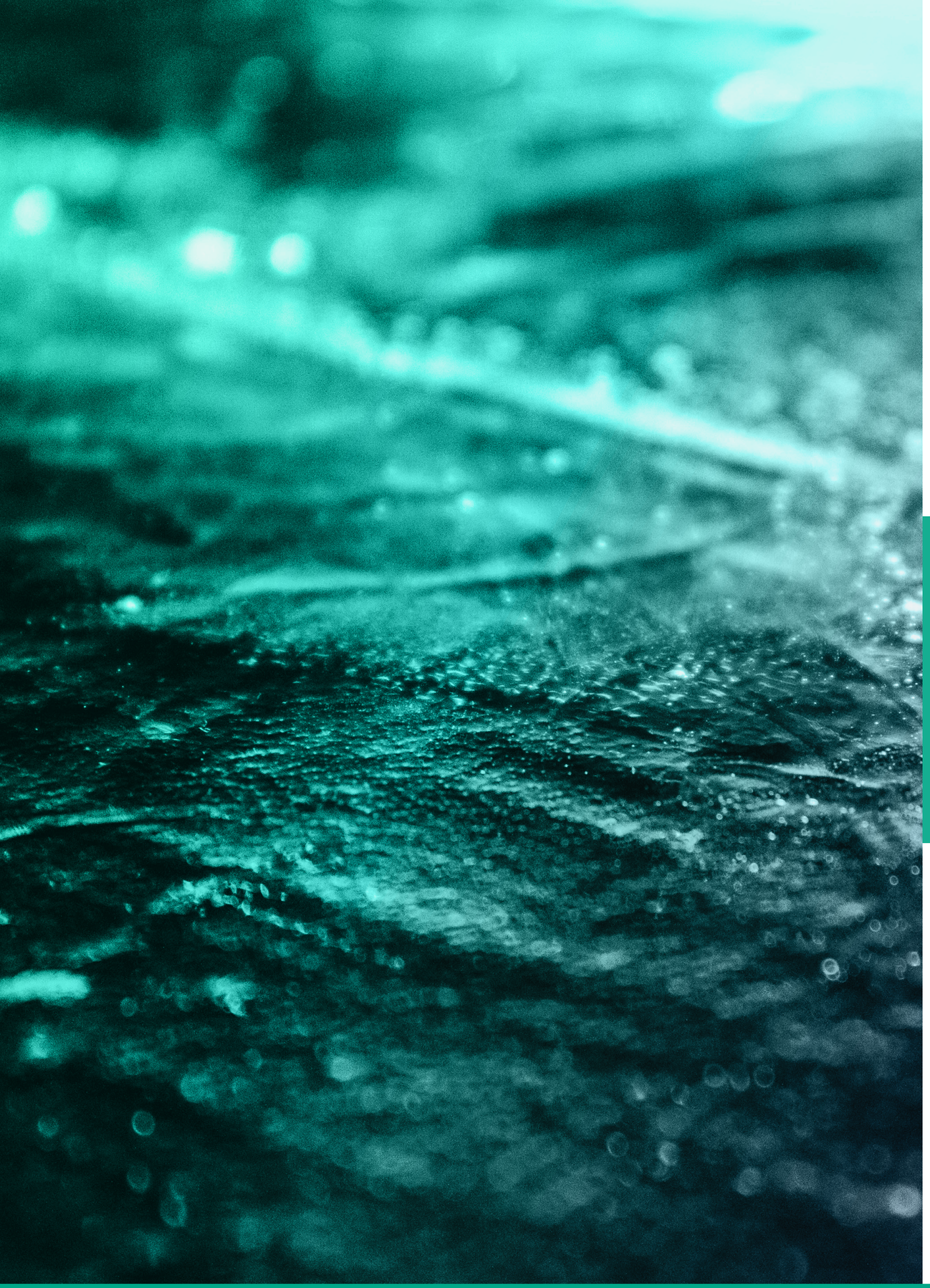
AIVL
Australian Injecting
& Illicit Drug Users League

HIDDEN HARMS

Methamphetamine use and routes of transmission of blood borne viruses and sexually transmissible infections



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July 2019

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ABBREVIATIONS

AIVL	Australian Injecting and Illicit Drugs Users League
BBV	Blood borne virus
DAA	Direct-acting antivirals
HCV	Hepatitis C virus
Meth	Methamphetamine
MSM	Men who have sex with men
NSP	Needle and syringe program
OMT	Opioid Maintenance Treatment
PWID	People who inject drugs
STI	Sexually transmissible infection

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AUSTRALIAN INJECTING & ILLICIT DRUG USERS LEAGUE (AIVL)

AIVL is the Australian national peak organisation representing the state and territory peer-based drug user organisations in relation to issues of national relevance for people with lived experience of drug use.

AIVL's vision is a world where the health and human rights of people who use/have used drugs are equal to the rest of community. This includes a primary focus on reducing the transmission and impact of blood borne viruses (BBVs) such as hepatitis C and HIV – including for those accessing drug treatment services – through the effective implementation of peer education, harm reduction, health promotion and policy and advocacy strategies at the national level.

Member organisations of AIVL are:

Australian Capital Territory (ACT)
Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) and The Connection

New South Wales (NSW)
NSW Users and AIDS Association (NUAA)

Northern Territory (NT)
Northern Territory AIDS and Hepatitis Council (NTAHC)

Queensland (QLD)
QLD Injectors Voice for Advocacy and Action (QuIVAA)
Queensland Injectors Health Network (QuIHN)

South Australia (SA)
Hepatitis SA Clean Needle Program Peer Projects

Tasmania (TAS)
Tasmanian Users Health and Support League (TUHSL)

Victoria (VIC)
Harm Reduction Victoria (HR VIC)

Western Australia (WA)
Peer Based Harm Reduction WA

EXECUTIVE SUMMARY

Methamphetamine (meth) use is a recognised issue in Australia which has garnered much attention over recent years. The focus of media reporting has largely been on aggressive and unpredictable behaviour of people who have used the drug. This is a narrow representation of the effects of the drug. Little attention has been given to the transmission of blood borne viruses (BBVs) and sexually transmissible infections (STIs) connected to the use of meth.

Whilst meth can, and is, injected by some there needs to be recognition that other routes of administration also carry risk of BBV transmission such as the normalised sharing of pipes. Furthermore, risky sexual behaviours associated with meth use also require attention to reduce the transmission of certain communicable infections.

Not all drug use is the same and subpopulations of drug use exists. These layers of complexity need to be recognised and investigated further to ensure that appropriate harm reduction messages are developed.

Through consultation with its member organisations, the Australian Injecting and Illicit Drug Users League (AIVL) has identified a number of current policies and legislation which needs to be reviewed in terms of the unintended effects it may have on encouraging harm and riskier drug consumption behaviours. For example, whilst it is known that needle and syringe programs (NSPs) work effectively to reduce BBV transmission through injecting practices, the difficulty of obtaining a meth pipe from which to smoke the substance, means that some have turned to injecting given the greater availability and ease of obtaining the necessary equipment.

In December 2018, the Australian Government released 5 national strategies which address both BBVs and STIs. These strategies provide robust and comprehensive frameworks from which progress can be made, however action towards the goals outlined must not fail to recognise subpopulations within the already identified priority populations.

Moreover, the stigma attached to meth use must not stand in the way of evidence-based harm reduction measures being adopted. Legislation and policies need to be developed and informed by evidence and not moral judgements, which also incorporates the valuable role that peers play.

Melanie Walker
Chief Executive Officer

June 2019

INTRODUCTION

Over the past decade, 'ice' or 'meth' have become terms that most households are familiar with to some extent. Media outlets regularly publish stories about the police remanding people for meth related offences, and the narrative of crazed ice users has become commonplace. The Australian Government's *Ice Destroys Lives* campaign also made a mark on the social consciousness of the Australian public.

Due to the above, meth use has become a highly stigmatised activity. People do not want to be known as meth users. A risk associated with this is that they may not be aware of the available harm reduction services and programs on offer to help ensure that their drug use is as safe as possible. With this in mind, it is also evident that more needs to be done to improve health promotion messaging as well as harm reduction programs and services specific to meth use.

There is minimal Australian-based research regarding meth use and its relationship with blood borne viruses (BBVs) and sexually transmissible infections (STIs) transmission, such as via smoking and through sexual activity. Much of the research focuses on issues of addiction and is written from an alcohol and other drug sector perspective. Whilst valuable, there has been less focus on the intersections between meth use and the transmission of BBVs and STIs. For example, there has been little focus on the potential risks associated with the cuts and sores in the mouth area that many meth users experience and how pipe sharing relates to BBV transmission.

In response to growing concern regarding the lack of meth specific harm reduction information and activities, the Australian Injecting and Illicit Drug Users League (AIVL) held a national consultation process, including a workshop in late 2018 with representatives from its 9 peer-based member organisations. Anecdotal feedback was received from representatives which shared the experiences of people who have come into contact with these peer-based services and programs. As a result, it became evident that more needs to be done to address the risk of BBV and STI transmission for people who use meth.

The *National Drug Strategy 2017-2026*, under the pillar of harm reduction, acknowledges that reducing risk behaviours, providing safer settings for drug use as well as supporting evidence-based best practice are all critical elements of reducing harms associated with drug use.[1]

This report focuses on the crystalline form of methamphetamine, commonly known as 'meth' or 'ice' as opposed to the powder form of amphetamine. The report highlights the various potential routes of BBV transmission associated with meth use and the current policy and legislative barriers which have adverse impacts on known harm reduction measures. A series of best practice guidelines are offered which could be implemented to improve the public health outcomes associated with meth use.

METHAMPHETAMINE USE IN AUSTRALIA

Methamphetamine (meth) is a stimulant drug. This means that it speeds up messaging between the brain and the body. Methamphetamine, also known as 'ice' owing to its clear crystal-like form, is a type of amphetamine which is stronger and more addictive than the powder form of amphetamine commonly known as 'speed'.[2]

Meth can be smoked or injected. Depending on the purity and route of administration, effects of the drug typically last between 4 - 8 hours.[3] [4] Thus the effects of meth far outlast the effects of cocaine. Meth provides users with what is commonly described as a euphoric feeling. Being a stimulant it increases energy and alertness, reduces appetite, and is known for its ability to increase sex drive and facilitate longer sexual episodes.[5]

Common issues associated with meth use include dehydration, sleep deprivation at times leading to psychosis and aggression, grinding of teeth, repetitive behaviours like scratching as well as implications linked to sexual performance and activity. Dependency on meth poses a serious public health concern across multiple areas such as the transmission of BBVs and STIs, heart issues related to increased heart rate as well as psychiatric concerns among others.[6]

Australia is one of the highest consumers of methamphetamine in the world.[7] The prevalence of meth has grown in recent years. The *National Drug Strategy Household Survey 2016* found that 1.4% of Australians over the age of 14 had used meth in the past 12 months.[8] Significant increases in the daily or weekly use of the drug were also reported; from 9.3% in 2010 to 20.4% in 2016.[9] There is little doubt that the use of meth and its associated harms are of concern.

Regional, rural and remote Australia

Increases in meth use have disproportionately affected regional, rural and remote areas of Australia.[10] [11] Despite common images and stereotypes portrayed in the media as to who is a meth user, many might be surprised to learn that the prevalence of meth use among employed rural residents is significantly higher than employed city and regional residents.[12]

The *National Drug Strategy Household Survey 2016* found that people who use crystal meth are more likely to live in outer regional, remote and very remote areas of Australia; this accounted for 22% of users compared to 6.4% who used the powder form of amphetamine.[13]

This is important data which needs to be factored into harm reduction messaging, programs and policy measures. Furthermore, access to existing harm reduction measures must be considered. Needle and syringe programs (NSPs) are an effective tool to reduce the transmission of BBVs. Injecting drug use that results in needle and syringe sharing is the major route of hepatitis C (HCV) and HIV transmission.[14]

Although Australia has a well-developed NSP network in metropolitan areas, access to NSPs in rural, regional and remote areas of the country is limited. Two thirds of Australia's pharmacy-based NSPs are located in major cities, with only 26% being located in remote areas and only 9% being located in what is classed as very remote areas.[15]

Stigmatisation of being a meth user

Meth use in Australia faces a particularly strong stigmatising label. As use has increased, so too has common societal perception that all meth users are unpredictable and violent. This image was further reinforced through a national Australian Government campaign in 2015 called *Ice Destroys Lives*.[16]

The mass media campaign targeted at population level ran for 6 weeks and cost taxpayers $9 million. It used shock-based messaging tactics which it was hoped would deter people from trying the drug or motivate people to stop using. The Australian Government was demonstrating what it saw as its response to the 'ice crisis'. Given the images used the campaign proved to be controversial.

Ultimately, negative and simplistic stereotypes of meth use were reinforced. Language used in the campaign was stigmatising and discriminatory – framing all meth users as aggressive, worthless and problematic.[17] An analysis of the campaign found that people who use meth felt the national campaign had adversely impacted their self-esteem and it increased their sense of social isolation.[18] Moreover, another direct adverse outcome of such campaigns is that they make people less likely to seek help and treatment because they fear being identified as meth users.[19] [20]

Consultations held by AIVL found that stigma among poly drug users is complex. Anecdotal feedback provided by member organisation representatives identified that opioid users often do not wish to be identified as meth users if they use both drugs. This is because of the negative image portrayed of people who use meth which has not only become commonplace in broader society but also within the drug-using community.

The above indicates the likelihood of underreporting of meth use, in particular, among the opioid using cohort. Feedback received alludes to opioid or opioid maintenance treatment (OMT) users obtaining opioid injecting equipment from NSPs and then attending pharmacy based NSPs to obtain the necessary equipment for the injecting of meth, so as not to be identified as meth users.

This behaviour demonstrates the ingrained effects and complexities of stigma with the result being that appropriate harm reduction messages are often not reaching their intended audience. It further highlights the need for targeted health promotion messaging and resources – not all people who use/inject drugs have the same experience or identify with one another. The best way to identify and understand such nuances is through peer-led programs, outreach and resources which encompass their perspectives and voices.

BLOOD BORNE VIRUS RISKS ASSOCIATED WITH METH USE

The use of meth through either injecting or smoking carries with it the risk of BBV transmission. Also associated with meth use are risky sexual behaviours which also carry the risk of transmission of BBVs along with STIs. Therefore, the public health risks connected to meth use need to be taken seriously and a suite of appropriate harm reduction measures developed and effectively implemented.

The narrative which is commonly found in the Australian media that demonises people who use meth is detrimental to ensuring that people who use meth engage with harm reduction programs and services.

Furthermore, an understanding of the different reasons why people use meth and the various influencing factors which may determine how they choose to consume the drug is vital. A one-size-fits-all attitude to harm reduction messaging is insufficient. For example, materials developed for opioid users may not be relevant to meth users. The effects of the drugs, and the social contexts relating to use, are different.

Injecting

The proportion of people injecting meth doubled from 9.4% in 2013 to 19.2% in 2016 according to the *National Drug Strategy Household Survey 2016*.[21] This is a striking increase and should be a sign that harm reduction messages regarding the injecting of meth need to be strengthened to prevent the transmission of BBVs.

During AIVL's National Consultation Workshop it was highlighted by members and representatives that there is significant poly drug use in relation to opioids and meth. This observation relates to both heroin use and people on OMT. It was reported that many people prefer to identify as opioid users rather than meth users due to the stigma attached to the latter.

A study was conducted in the ACT which did shed light on some of the issues surrounding poly drug use. Of the people surveyed, 37% of those using meth were also enrolled in OMT.[22] This data highlights the crossover between opioid and meth use. At present minimal research and information exists regarding this subpopulation with it being evident that it is an area requiring additional investigation. Furthermore, the majority of research participants nominated injecting as their preferred means of consumption.[23]

Whilst people who demonstrated poly injecting drug use had awareness and knowledge of needle and syringe programs (NSP), participants who solely injected meth had lower awareness of this effective harm reduction measure. It is was also notable that the cohort that typically injects is of an older age demographic.[24]

Recent research from the US shows a strong connection between injecting meth use and HIV risk growing among men who have sex with men (MSM).[25] Of the men surveyed, 40% reported the sharing of injecting equipment with non-MSM. Whilst this study was conducted in the US, it highlights the importance of ensuring that all cohorts who inject drugs are aware of the risks associated with the sharing of injecting equipment.

Reducing harm from injecting

Whilst there exists a well-established network of NSPs throughout metropolitan Australia, work needs to be done to ensure that people who inject meth, and particularly those in regional, rural and remote areas are aware of these services and also have access to them. Given that it is known that rates of meth use in regional, rural and remote areas of the country are high, equity of access remains an issue.

Connected to the lack of NSP access in regional, rural and remote areas is current state and territory legislation which prohibits peer distribution of sterile injecting equipment. The acquisition of sterile injecting equipment from personal sources, such as friends, or acquaintances, (known as a 'peer' or 'secondary distribution') is a common way that people who inject drugs access sterile injecting equipment. While these acts of goodwill extend the benefits of NSPs, this practice has varying legitimacy across Australian jurisdictions and its inconsistent legal status undermines governments' goals to reduce new BBV transmissions.

Each state and territory provides legislation allowing for the distribution of sterile injecting equipment in its jurisdiction (see Appendix C). At present two jurisdictions (ACT and Tasmania) explicitly allow for the supply of sterile injecting equipment by non-health professionals, while the Northern Territory allows for peer distribution as a defence in cases where a person is not able to obtain sterile injecting equipment from a registered provider.

Smoking meth

The smoking of meth is also associated with many negative health consequences and is linked to the transmission of BBVs. Although the negative impacts of smoking meth are less in comparison to intravenous use, this route of administration still produces a rapid effect whilst also being addictive. For many, especially those who are not already injecting drugs users, smoking meth provides a gateway to the drug. A study of the demographics of meth users in the ACT found that smoking is more strongly correlated to a younger demographic, with this trend on the increase.[26]

Given that the selling and purchasing of 'ice/meth pipes' is illegal across all Australian jurisdictions many users resort to homemade pipes. These makeshift pipes can be made from materials such as glass fragments, lightbulbs and aluminium cans. A particular issue with homemade implements is that they are more likely to cause cuts, burns, blisters and open sores inside the mouth and on the lips.[27]

Damage and injury to the mouth area is commonplace among meth users. A study of people who smoke meth in Toronto, Canada found that of the participants interviewed; 35% had cracked lips, 35% had burns and cuts to their hands, and 18% had burns or cuts to their lips.[28] The risk associated with such injuries is that blood-to-blood contact may occur through the sharing of smoking equipment.

Studies in North America have examined the risk of HCV transmission via crack cocaine paraphernalia.[29] Whilst the smoking implements are somewhat different compared to those used for smoking meth, the injuries and risk for BBV transmission are comparable. For example, a risk found associated with smoking crack was that it heightened one's vulnerability to HIV transmission during activities such as sharing pipes or oral sex.[30]

Another study in the United States of crack smokers found an elevated risk of BBV transmission due to burns and cuts from the use of pipes. Findings also suggested that people who smoke in public may be at increased risk due to the criminalisation of the act so it is often undertaken in a rushed manner.[31] Rushed use was shown to be associated with inattention to hygiene and a lack of harm reduction practices which exacerbates the risk of infection.

The reason such cuts and sores pose a risk is because the act of smoking is a highly socialised one. Pipe sharing among people who use meth is widespread which is also underpinned by a casual attitude regarding associated risks.[32] Research in the ACT found that pipe sharing was a normalised activity with 28% of participants who share pipes reporting burns or sores on their lips.[33] A study in the US also found that the sharing of meth pipes was commonplace in bathhouses, with only one or two pipes available within a large group setting.[34]

Overall, many people do not consider BBV transmission whilst sharing a pipe as much as they may consider it if sharing injecting equipment.[35] Study participants reported greater concern about the breakage of pipes or people smoking more than their fair share, compared to concern of BBV transmission.[36] Given that smoking is more of a social behaviour and often done in group settings (compared to injecting), changing the behaviour of pipe-sharing may prove to be more challenging.[37]

Reducing the harm from smoking

Relevant health promotion and harm reduction measures regarding pipe use need to reach the appropriate target audience. Users should be informed of the risks associated with pipe sharing. Evidence shows that BBV transmission is not a main consideration or concern for the majority of people who smoke meth. Consideration should be given to the different demographics of people who smoke meth as well as the reason for which they choose to smoke.

The implications of current legislation which prohibits the selling, purchasing and use of ice pipes needs to be considered within this context. The 'tough on crime' approach adopted by law makers and law enforcement has unintended consequences. Feedback has been received from AIVL's member organisations and representatives that people have taken to injecting meth as it is easier for them to obtain injecting equipment than pipes.

The smoking of meth should be made as safe as possible for users. The specialised pipes needed for this purpose could easily be made available and distributed through the existing network of primary and secondary NSPs. Canada has seen the development and implementation of 'safer smoking kits' (see Appendix A).[38] Similar to a 'fit' pack that a person who injects drugs obtains from an NSP, a smoking kit contains all the necessary equipment to ensure safer smoking practices.

Another measure to reduce harm is supervised inhaling rooms.[39] Whilst supervised injecting rooms exist, the concept of inhaling rooms has been slow to catch on. If co-located with injecting rooms, an inhaling space could foreseeably promote transitioning from injecting to less risky forms of consumption such as smoking.[40] This could also provide a space where sterile and safe smoking equipment is distributed.

Sex and meth

AIVL's National Consultation Workshop highlighted the concern amongst peers regarding meth use and BBV/STI transmission associated with sexual activity. A significant and well-documented effect of meth is sexual stimulation. As sexual inhibitions decrease, safe sex practices lessen and the increased likelihood of risky sexual behaviour directly connected to meth use provides a platform for greater likelihood BBV and STI transmission.

The *Fourth National Sexually Transmissible Infections Strategy* acknowledges; "The correlation between methamphetamine use and increased risk of STIs has been well documented and there is increasing evidence that this may also apply more widely to injecting drug use, non-medical use of prescription drugs and other illicit drug use".[41]

Over recent years there has been plethora of research into the phenomenon of 'chemsex' which is a term now connected to the use of certain illicit drugs, including meth, and men who have sex with men (MSM). The effects on this community are well documented. Less research is available on the effects among heterosexual meth users, in particular women.

Meth is linked to risky sexual behaviours.[42] Use of the drug facilitates longer sexual episodes. An issue with this being that it leads to the drying of the mucosa which can cause tears in the rectal and genital region.[43] [44] The longer and the rougher the sex, the greater the increased opportunity for BBV and STI transmission. Moreover, the use of meth impairs men from reaching climax, this combined with the use of Viagra, means that some men have sex to the point of wearing off skin from their penis.[45]

The pleasure of meth

Research shows the neurological effect of meth on the brain and its ability to increase sexual desire.[46] As a stimulant, meth works by increasing the neurochemical amplification of pleasure. Therefore, emotions are intensified, energy is increased, self-esteem is elevated, sexual arousal is heightened, inhibitions are reduced and judgement is impaired.[47]

Meth has been described as allowing one to open a Pandora's Box of sexual desires and fantasies.[48] Users describe the experience of sex whilst high on meth as 'immensely pleasurable and disinhibiting'.[49]

Often research, social narrative and media reporting ignores the sense of positive aspects of meth use that some users report. Enhanced sexual pleasure and disinhibited sexual experiences are aspects that are clearly an appealing effect of the drug and should not be ignored or dismissed when trying to understand drug using behaviour.

That is not to suggest that the connection between meth and sex is not without its problems. Addiction to meth can draw links between the craving for the drug as well as sex, which can become a complex connection leading to anhedonia: the inability to experience pleasure from activities usually found pleasurable. This is because of the high amounts of dopamine released through meth use which leads to a diminishing ability to enjoy simple human pleasures.[50]

Unsafe sex

Studies of heterosexual meth users have found that whilst disinhibited by the drug, they are significantly more likely to engage in anal sex.[51] [52] [53] Anal sex poses a greater risk for the transmission of BBVs and STIs as tissue is more delicate and tears with greater ease. Furthermore, heterosexual males who use meth are also more likely to engage in sexual activity with a person who injects drugs (PWID).[54]

A study of incarcerated heterosexual males in Sweden found that people who use meth reported more female sexual partners compared to people who use opioids.[55] Similar findings were recorded regarding females who inject meth; they reported greater interest in sex and more frequency of intercourse than people who inject opioids along with lower rates of condom use.[56]

Meth use is clearly associated with higher rates of unsafe sexual encounters. One study found that condoms were used only 52% of the time by meth users engaging in anal sex.[57] Given the risky sexual behaviours connected to meth use such as; condom-less sex, higher incidence of anal sex, more sexual partners, this indicates that meth use is likely to contribute to a higher incidence of BBVs and STIs among the non-injecting drug using cohort.[58] [59]

Chemsex

Meth has become tied with the concept of 'chemsex'. There are varying interpretations and definitions of the term however it is most commonly understood to be the consumption of specific drugs by gay men and MSM.[60] The most commonly used drugs for this purpose are meth, cathinones and GHB. It is the high achieved from these substances in particular that enhances sexual pleasure and lessens inhibition.

More recently 'slamming' parties have become more prevalent in Australia. This is when meth is injected to give a longer lasting effect and attendees at the party engage in weekend or even week long sex parties. It is reported that the sharing of needles and lack of condoms is common at such events.[61]

People have been using drugs and alcohol for sexual enhancement for thousands of years.[62] This is not a new phenomenon. However, people involved in the chemsex scene report a high degree of stigma associated with their meth use and therefore may be less likely to seek treatment for problematic substances use or concerns relating to BBVs and STIs.[63]

Marathon sex

Marathon sex is a term generally used for sexual intercourse which lasts for several hours. It is a concept prevalent among people who use meth and is more strongly associated with heterosexual meth users.[64] [65] Marathon sex can be achieved due to meth reducing inhibitions, increasing the duration of erections and delayed ability to reach climax. For men, the effects of this can lead to sexual dysfunction as over time their performance may be adversely affected by the prolonged use of meth. There are, at times, further problems and repercussions for the individual and others associated with this dysfunction.

Studies have found that users reported having sex for hours without feeling tired or the need to take a break.[66] Other studies have also found meth being used within the heterosexual swinging community to prolong sexual experiences.[67]

Women's experience of marathon sex can be linked to meth use as well. One participant of research described the inherent connection between her use of meth and marathon sex; "… marathon sex, I don't think I would ever do that without being high… it's not my normal thing. But when you're high, that's real – I mean, I've done that quite a bit. Yeah. But never not high."[68]

Women and meth

No different to the many men who are documented to experience increased sexual desire, drive and prolonged performance – women too have similar experiences. A study of a female meth users found that women reported feelings of confidence, allayed insecurities and a lessening of body image issues connected to meth use.[69] One woman interviewed stated; "Meth is my sex drug".[70]

Women who use meth report a greater number of sexual partners than non-users.[71] This is also combined with less condom use and more anal sex. Studies have shown that, for the most part, women's sexual partners are also meth users. When both people engaging in sex are using meth, the more likely prolonged and rough sex is to occur. Thereby, women who use meth are at a greater risk of the transmission of BBVs and STIs.

Whilst past trauma has been linked with some women's meth use, helping them to dissociate from past experiences; many women have discussed a positive correlation between meth use and their experience of sex.[72] [73] [74] Women are often taught by society to attach feelings of shame to their sexuality however with the use of meth women have described a sense of sexual agency they have not experienced whilst sober.[75]

Reducing harms when having sex whilst on meth

Safe sex messaging needs to be reconsidered for people who use meth. Critically, as part of this, the positive sexual experiences that many people report, especially women, should not be dismissed and ought to be recognised in how appropriate materials are developed. Ignoring the reasons why people may engage in this aspect of meth use runs the risk of alienating and dismissing their experiences as irrelevant.[76]

Harm reduction messaging also needs to recognise that marathon sex is occurring within the heterosexual meth using community, it is not solely a MSM issue.

Moreover, it has been identified that increased risky sexual behaviour is happening among people who inject meth but do not inject heroin. As it is known that this group has less awareness of NSPs which generally offer educational health promotion materials. This means that new ways to get messages to this cohort need to be developed. Conversely, it is known that it is a younger demographic that typically smokes meth – again, engagement with NSPs is unlikely to occur among this group, consequently safe sex messaging needs to be dispersed in a way more likely to reach them.

As with many harm reduction measures, workforce development plays a critical role to ensure that frontline primary health care practitioners are aware of these risk behaviours common among people who use meth. They need to be well equipped to know which questions to ask and actions to take in response.

BEST PRACTICE GUIDELINES

Understanding the effects of meth, both positive and negative, and the variety of reasons for which people consume it, is key to developing effective harm reduction and health promotion materials and measures. Simply labelling all people who use meth as 'bad' or 'problematic' is not only stigmatising and inaccurate, but it impedes the achievement of public health outcomes for the individual and the broader community.

The *National Drug Strategy 2017-2026* speaks of reducing risk behaviours and providing safer settings in relation to drug use. In order for this to happen and for the goals of five new National BBV and STI Strategies to be achieved, further work needs to be undertaken in collaboration with a variety of sub-populations who use meth to develop effective health promotion and harm reduction messaging.

To enhance responses to decrease the transmission of BBVs and STIs the following should be considered:

1. Reform of peer distribution laws in regard to injecting equipment

Despite its illegality in most states and territories, the practice of distributing sterile injecting equipment occurs regularly, with studies finding that people who undertake a peer-distributing role on a large scale have significant reach and volume, and have helped avert countless BBV transmissions within the community.

Although there are not widespread examples of prosecution under state and territory laws, people who inject drugs and NSP service providers are aware of the existence of such legislation and are cautious about its implications. It is also common for community members to describe experiences of escalating law enforcement after they disclose giving or receiving injecting equipment from peers, or being found in possession of injecting equipment. The existence and consciousness of legislation that places limits on access to sterile injecting equipment places at risk the Australian Government's ability to achieve the goals of the National BBV and STI Strategies, while simultaneously providing an environment where preventable BBVs are transmitted.

Removing legislative barriers to peer distribution would allow this practice to flourish without fear of prosecution as well as enabling NSPs to encourage and support the practice amongst their clients. Reforming laws to enable peer distribution in each jurisdiction is therefore a cost-effective way of enhancing the current capacity of NSPs to reduce harm.

2. 'Safer smoking kits' or meth/ice pipes to be made available in NSPs

It was noted during AIVL's consultations that some people who use meth have taken to injecting as acquiring purpose-made meth/ice pipes is difficult. By allowing regulated access to pipes or 'safer smoking kits' through the existing network of primary NSPs this would allow those wishing to smoke meth to do so with sterile and safe equipment, diverting them away from injecting and from sharing damaged and dangerous clandestine made equipment.

Inhalation rooms should also be considered as a complimentary harm reduction measure which can provide a safe environment for consumption, similar to that of existing medically supervised injecting facilities in Kings Cross in News South Wales and Richmond in Victoria.

3. Enhance capacity of peer-based programs and services as this is a critical means to engage with "hard-to-reach" populations

Studies have shown that people who use drugs are more likely to seek support, help or treatment from peer-based services and programs. Greater investment in and resourcing of peer-based programs is critical if harm reduction messages are going to reach the people that they are intended for.

The importance of peer-to-peer education is recognised and well documented. Peer education has been adopted in health promotion owing to its effectiveness over clinically delivered services in terms of messaging and cost benefits.
The effectiveness of peers owes to others seeing them as a credible source of information and being viewed as trustworthy which other professionally delivered services struggle to achieve due to a lack of rapport. Furthermore, it is known that stigma and distrust typically drives people who use/inject drugs away from accessing essential health care. As such peers can provide moral support and help overcome this barrier.

4. Safe sex messaging tailored to different demographics, including women, heterosexual men, young people and non-injecting drug users

It is known that meth use leads to a higher incidence of riskier sexual behaviour among all demographics. Appropriate safe sex messaging needs to tailored to people who use meth in a way that is relatable to their experiences. Again, one size does not fit all within this kind of messaging and resourcing needs to be put into focus group testing with peers to ensure that what is developed is relevant to the intended audience.

Furthermore, knowing where to distribute such information is critical. As outlined above, younger people as well as people who do not inject meth are less likely to be aware of or engage with NSPs unlike the older cohort of people who inject opioids.

AIVL's membership of peer-based drug user organisations is well-placed to facilitate engagement with a range of drug using sub-populations, including non-injectors.

APPENDIX A: SAFER SMOKING KITS[77]

An example of components included in 'safer smoking kits' in Canada.

Item	Reasons to include
1 or 2 Pyrex or tempered glass pipe	To prevent breakage
Lighter	
Scoops	To put crystal methamphetamine in bowl
Scrapers	To scrape out residue
Alcohol wipes	To clean pipe after use
Tin foil and straws	For 'chasing the dragon'
Hand sanitizer	
Condoms	
Lubricant	To prevent tissue tears
Mouthwash	
Lip balm	For cracked lips which can lead to blood-to-blood contact
Band-Aids	For any cuts that may be sustained
Gum	For dry mouth
Electrolyte powder	Due to loss of appetite
Educational information	Information about health risks, crisis phone numbers etc.

APPENDIX B: CONSULTATION WORKSHOP OUTLINE

Consultation Workshop 1 – "People who use methamphetamines and emerging BBV/STI trends"

Introduction

There is a wealth of international research - and anecdotal evidence emerging in Australia – exploring the particular BBV/STI risks applicable to methamphetamine users. A particular emerging issue is recognising the specific BBV/STI transmission risks that are applicable for different routes of administration (smoking as well as injecting).

There are three parts to this process:

1. Providing this information ahead of the workshop so that participants can consult with their friends and colleagues beforehand;
2. Going through the consultation questions below in a group at the Annual Meeting to enable identification and discussion of emerging trends and issues; and
3. Follow-up with member organisations post-Annual Meeting.

Questions

1. What proportion of your organisation's service users do you think use methamphetamines? Is this estimate based on statistical data or an informed view (you are all 'key informants' in this context)?
2. Are you able to estimate what proportion of your service users who are using methamphetamines are smoking or injecting? Is this estimate based on statistical data or an informed view (remembering you are all 'key informants' in this context)?
3. Do you think there are specific BBV/STI transmission risks that are particular to people who inject methamphetamines (as opposed to people who inject other substances)?
4. Do you have any knowledge about whether methamphetamine users are accessing vending machines and pharmacies rather than primary NSPs? If so, why do you think this might be?
5. Are pipes illegal in your jurisdiction? If so, is this contributing to people transitioning to injecting?
6. What do you think the key BBV/STI transmission risks are for people who smoke methamphetamines? For example, thinking about things like the potential for blood-to-blood contact and other risk-taking behaviours.
7. Are there BBV/STI transmission risks that are common to both people smoking and injecting methamphetamines?
8. Have you heard of methamphetamine users not wanting to access services due to recent negative media portrayal and resultant stigmatisation?
9. Are your experiences of working with people who use methamphetamines anything like the negative media portrayals?
10. What additional services would your organisation want to provide to support people using methamphetamines? Please provide a brief description.
11. Are there other questions you think we need to be asking? If so, what would they be and why should we be asking them?

APPENDIX C: POLICY STATEMENT

POLICY STATEMENT ON LEGISLATIVE BARRIERS TO PEER DISTRIBUTION OF STERILE INJECTING EQUIPMENT

Background:

Australian Needle and Syringe Programs (NSPs) have been highly effective in reducing the transmission of blood borne viruses among people who inject drugs and ensuring wide access to sterile injecting equipment forms a key part of Australian governments' responses to blood borne viruses.

Despite the absence of legislative support, the distribution of sterile equipment also occurs within the community. Research illustrates that this type of engagement reaches groups that face barriers in accessing formal NSPs, including people who use drugs and live in regional, rural and remote settings and Aboriginal and Torres Strait Islander people who use drugs.

The acquisition of sterile injecting equipment from personal sources, such friends or acquaintances, (known as 'peer' or 'secondary distribution') is a common way that people who inject drugs access sterile injecting equipment. While these acts of goodwill extend the benefits of NSPs, this practice has varying legitimacy across Australian jurisdictions and its inconsistent legal status undermines governments' goals to reduce new blood borne virus transmissions.

Each state and territory provides legislation allowing for the distribution of sterile injecting equipment in its jurisdiction. At present two jurisdictions (ACT and Tasmania) explicitly allow the supply of sterile injecting equipment by non-health professionals, while the Northern Territory allows for peer distribution as a defence in cases where a person is not able to obtain sterile injecting equipment from a registered provider, such as
a pharmacist.

The table below provides an overview of legislation in each state and territory.

Jurisdiction	Relevant Act & Section	Legality of Peer Distribution
Australian Capital Territory	*Medicines, Poisons and Therapeutic Good Act 2008 – Section 37*	**Legal** Peer distribution allowable as a means to prevent blood-borne virus transmission
Tasmania	*Public Health Act 1997 – Section 56K(4)*	**Legal** A person supplying sterile injecting equipment is not guilty of an offense under the *Misuse of Drugs Act 2001, Poisons Act 1971 or Criminal Code*
Northern Territory	*Misuse of Drugs Act – Section 12(3)*	**Legal through defence** Section 12(2) makes the provision of sterile injecting equipment by an unauthorised person illegal, however Section 12(3) can be used as a defence for peer distribution if sterile injecting equipment is obtained from an authorised source
Victoria	*Drugs, Poisons and Controlled Substances Act 1981*	**Illegal** Only specified people, classes of people or authorised organisations are able to supply sterile injecting equipment
South Australia	*Controlled Substances (Prohibited Substances) Variation Regulations 2007*	**Illegal** Only medical practitioners, pharmacists or people acting in the course of a health risk minimisation program can supply or sell sterile injecting equipment
New South Wales	*Drugs Misuse and Trafficking Act 1985 – Section 11(2)*	**Illegal** Only health professionals and other authorised persons can supply sterile injecting equipment
Queensland	*Drugs Misuse Act 1986 – Section 10(3)*	**Illegal** Only health professionals and other authorised persons can supply sterile injecting equipment
Western Australia	*Medicines and Poisons Act (2014): Medicines and Poisons Regulations (2016), Part 10.*	**Illegal** Only authorised organisations can apply for license to supply sterile injecting equipment from the CEO WA Department of Health.

Key issues:

Peer distribution of injecting equipment expands the reach of sterile needles and syringes to people who inject drugs who face barriers in accessing formal NSPs, such as women, younger people, people new to injecting, those living in rural/regional/remote areas and Aboriginal and Torres Strait Islander communities.[1] [2] This is achieved in a cost-effective way as the practice is primarily driven by altruism and a goal of ensuring that others in the community do not contract blood borne viruses.[3]

Despite its illegality in most states and territories, the practice of distributing sterile injecting equipment occurs regularly, with studies finding that people who undertake a peer-distributing role on a large scale have significant reach and volume, and have helped avert countless blood borne virus transmissions within the community.[4]

Although there are not widespread examples of prosecution under state and territory laws, people who inject drugs and NSP service providers are aware of the existence of such legislation and are cautious about its implications. It is also common for community members to describe experiences of escalating law enforcement after they disclose giving or receiving injecting equipment from peers, or being found in possession of injecting equipment. The existence and consciousness of legislation that places limits on access to sterile injecting equipment places at risk the Australian Government's ability to achieve the goals of the national blood borne virus strategies, while simultaneously providing an environment where preventable BBVs are transmitted. Removing legislative barriers to peer distribution would allow this practice to flourish without fear of prosecution as well as enabling NSPs to encourage and support the practice amongst their clients. Reforming laws to enable peer distribution in each jurisdiction is therefore a cost-effective way of enhancing the current capacity of NSPs to reduce harm.

Recommendations

- That legislation across states and territories be amended to allow the distribution of sterile injecting equipment by non-health professionals.
- That current NSP regulations, support, and professional development are reviewed to enable community distribution of equipment.

This policy document was adopted by AIVL and our member organisations in 2017 and is due for revision in 2020.

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