SAFER SMOKING: AN ASSESSMENT OF SMOKING SUBSTANCES & ACCESS TO SMOKING DEVICES

MARCH 2020

Healthy Sexuality & Harm Reduction, WRHA

Team Members

Joseph Keilty
Marlee Mykietowich
Alisha Rana
Karla Slater

Shelley Marshall
Paula Migliardi

Interview Sites

Main Street Project
Mount Carmel Clinic
Nine Circles Community Health Clinic
Sage House, Mount Carmel Clinic
Street Connections, Healthy Sexuality & Harm Reduction, WRHA

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Acknowledgments

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INTRODUCTION

Healthy Sexuality and Harm Reduction (HSHR)/Street Connections launched the Safer Crack Use Kit distribution program in 2004. This occurred at a time when crack cocaine (crack) was prominent in Winnipeg. However, even amidst a shift in the drug market and circulation of crack diminished, there has been a remarkable increase in the distribution of Safer Crack Use Kits (SCUKs) in Winnipeg.

Between 2017 and 2018, the distribution of SCUKs doubled.[1] Their distribution through Street Connections mobile unit (the Van), and HSHR office has remained somewhat steady in the last 3 years. On the other hand, distribution through our community partners continued to grow.

Anecdotal information suggested that people who smoke drugs were modifying straight stems for the purpose of smoking crystal methamphetamine (meth) or using parts of the kits for smoking cannabis, and that they were encountering differing distribution practices across sites.[2] Ongoing monitoring of how SCUKs were used among service users to HSHR/Street Connections harm reduction supply distribution program led to changes to the products included in the kits. For instance, the brass screens were discontinued as clients were more likely using the stems for meth use or the screens, for smoking cannabis.

With increased availability of meth, a drug that is amenable to many forms of consumption, an increase in harm reduction supply distribution is not surprising. Distribution of safer injection drug use supplies has increased between 20 to 30 percent year over year since 2015 reaching over 2.5 million needles in 2019-2020. While harms addressed with needle distribution are well documented, questions as to what harms are been addressed through SCUKs distribution remain elusive.

HSHR is also facing an increased interest from community partners that want to distribute harm reduction supplies, and access to sharps containers to conduct needle disposal clean-ups. In view of the increased interest and demand for harm reduction supplies, an assessment of smoking substances and access to smoking devices is required to inform harm reduction supply distribution in Winnipeg.

Objectives

- To assess the smoking substances practices and access to smoking devices in Winnipeg
- To determine possible changes to HSHR/Street Connections smoking devices distribution guidelines
- To assess the published evidence on SCUKs and other safer smoking devices (in the context of meth use)

Assessment Questions

- What does drug use look like among people who smoke substances (other or in addition to cannabis) among service users attending supply distribution sites in Winnipeg?
- How do individuals access and use smoking devices in Winnipeg?
- How does access to smoking supplies impact on injection practices?

METHODS

A survey was designed to answer our assessment questions. The survey tool was reviewed by Indigenous health colleagues. The questionnaire was administered later in 2019 at largest harm reduction supply distribution programs in Winnipeg. A group of new Public Health Nurses

[1] WRHA (2019). Healthy Sexuality and Harm Reduction Program Monitoring Report, Jan-Dec 2018.
[2] Current guidelines limited to two glass stems per day, packaged with two mouthpieces.

from HSHR team collected the data. The survey was promoted around the time the interviewers were available at each site. Upon asserting the eligibility for the survey, a program staff invited and ushered participants to a private room for the interview. The interviewers then sought full consent for participation prior to conducting the interview.

Confidential qualitative interviews followed the completion of the survey. This interview was designed to gain in-depth understanding on how people smoke their substance, with a focus on the relationship between smoking and injecting. Ten interviews were conducted by HSHR's Program Specialist. The interviews were all conducted with participants coming to the HSHR office. They lasted about 20 minutes. A gift card was provided to participants.

SURVEY PARTICIPANT SAMPLE

A total of **225 participants** responded to the questionnaire. **Of those, 29 indicated to have only smoked cannabis.** As one of our main objectives was to identify access to smoking devices for people who use illegal drugs, responses from cannabis only users were not included in the analysis. **Therefore, the ultimate sample included 196 respondents.**

Over half (56%) of these respondents were interviewed at Healthy Sexuality and Harm Reduction/Street Connections' office, 496 Hargrave. The rest were interviewed at largest community run harm reduction supply distribution sites, namely, Mount Carmel Clinic, Nine Circles Community Health Centre and Main Street Project.

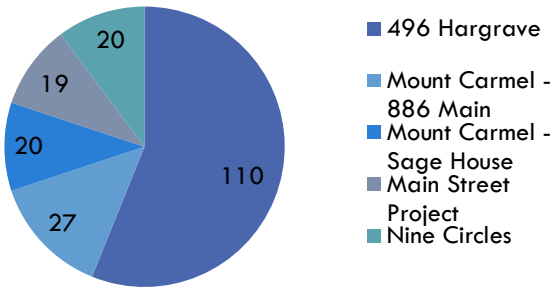

Fig. 1- Number of participants by interview site

PARTICIPANTS PROFILE

Age

Participants ranged from age 19 to 68. The average age was 39.5 years. As shown in the chart below, near a third of the respondents were ages 30-39. This was followed by 27% who were between the ages of 40-49. A fifth of participants were both among the younger sub-set of respondents (19-29), and the older sub-set (50+).

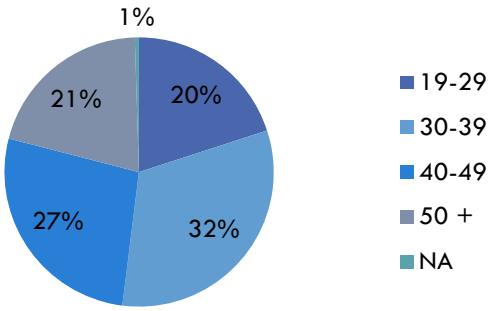

Fig. 2 – Participants' Age

The average age of female identified participants was 37 years old. The average age of male identified participants was 42. Among Two Spirit participants, the average was 38 years of age. Indigenous female participants were slightly younger than males. Their average age was 37; while for Indigenous male, it was 40.5 years of age.

Ancestry/cultural group

Three quarter (75%/n=147) of respondents indicated being Indigenous. This was followed by 10% who identified their ancestry as European, and 6% who said to be Canadian (See Fig. 3). Among the Indigenous participants, 77% identified as First Nations, most of whom reported their community or ancestry or cultural group.

32 First Nations communities were named. 39% of communities named were in Manitoba's Northern region, 25.5% were in the Interlake-Eastern RHA, 14% in the Prairie Mountain Region, and 17.5% in

the Southern Region. 2 participants identified communities in Ontario.

As per cultural groups named (n=35), respondents identified as Indigenous (31%), or more specifically as Cree (31%), Ojibway (14%), Oji-Cree (11.5%) or Saulteaux (11.5%). The rest (n=2), identified as Sioux and Mohawk.

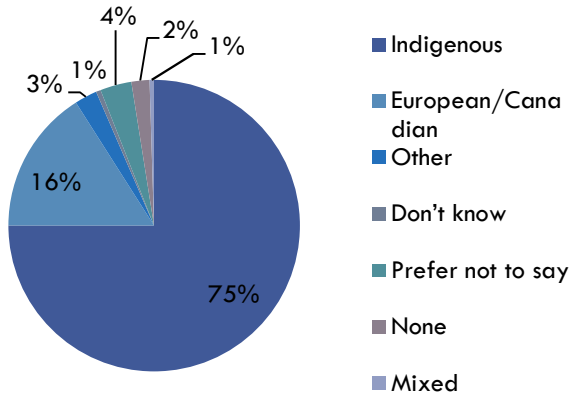

Fig. 3 – Participants' Ancestry

Gender Identity

Over half of the respondents identified as male (53%). Females constituted 43% of the respondents. Among the remaining participants a few identified as Two-Spirit or as another gender identity. Notably, 84% of female participants were Indigenous, while 70% of male participants identified as Indigenous.

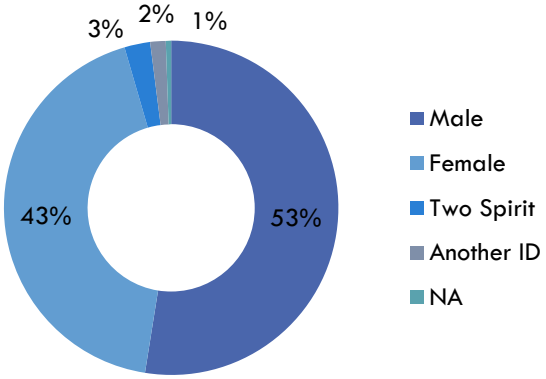

Fig. 4 - Participants' gender identity

Housing Status

40% of respondents were living in their own house or apartment around the time of the survey. This was followed by a distant 14% of participants who were residing with family or friends. A similar proportion was sleeping on the streets or shelters. Couch-surfing was mentioned by 13% of participants. The rest also identified, supportive housing (4%), single room occupancy or hotel (4%), boarding or rooming house (3%) and partner's residence (3%) as current places of residence or sleeping arrangements. When added together, most participants appeared to live in precarious housing situations.

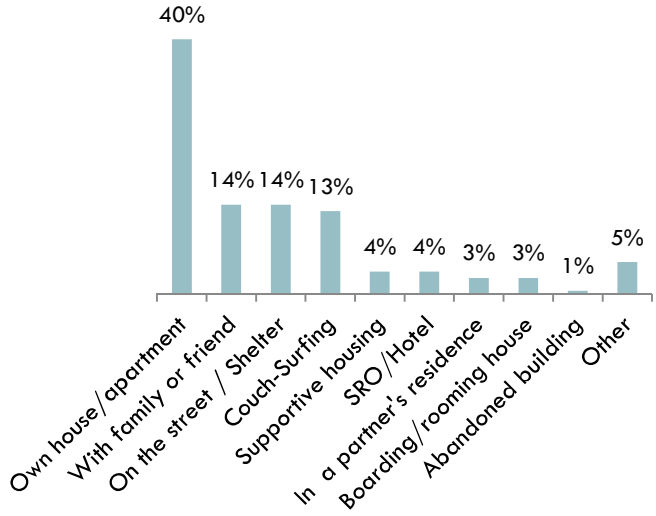

Fig. 5 – Participants' housing arrangements

Considering the surveys took place in organizations in the Downtown and Point Douglas areas, it is not surprising that most participants were living in Winnipeg's core area (60%), and the Point Douglas or North End neighborhoods (27%). However, many other neighborhoods were also named, including St Boniface and South St Vital, St James, Charleswood, North Kildonan and Elmwood. A few participants were from outside Winnipeg.

FINDINGS

Substances smoked

Most participants indicated having smoked more than one type of substances in the past 6 months. Most notably, 84% had smoked cannabis, followed by **77% who had smoked meth**. **About 58% indicated having smoked** crack (see fig. 6). Most who smoked cannabis (96%) smoke either or both, meth and crack (i.e., 34% smoked these 3 substances).

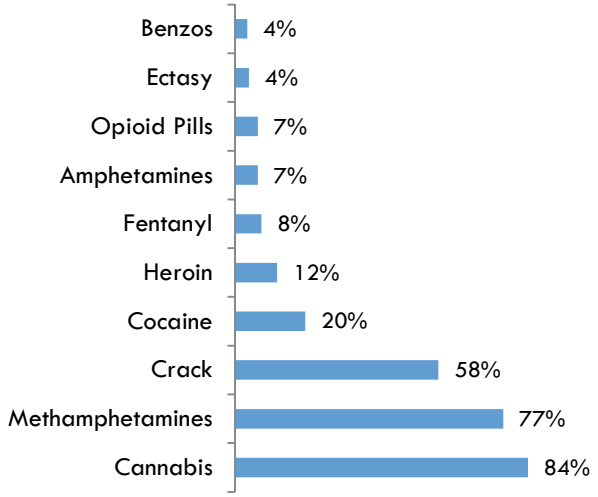

Fig. 6 – Substances smoked

In our sample, **38% of respondents only smoked** substances along with or other than cannabis. Among these there were **more males than females who only smoked**. Among only smokers, 63.5% were males, and 36.5% were females. The rest smoked and injected substances.

Frequency of smoking (other than cannabis)

In the last month to the survey, 40% of respondents smoked substances every day. Twenty percent smoked 3 or more times a week, and 19%, once or twice a week. The rest indicated having smoked occasionally, not every week (see fig. 7).

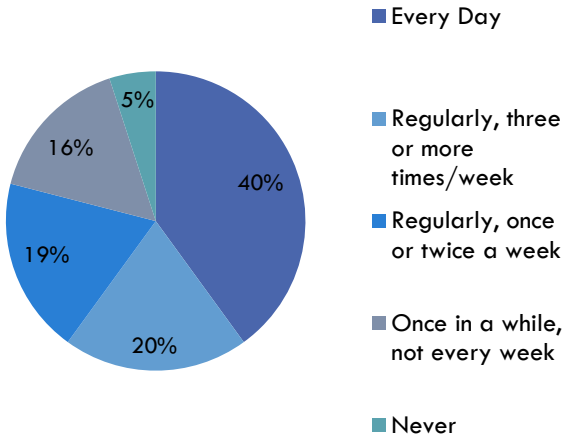

Fig. 7 – Participants' frequency of smoking

Among those who smoked every day (n=79), most (38%) smoked 4 to 7 times a day, and about 30% smoke 1 to 3 times a day. Several respondents (17%) smoked more than 8 times a day. Over 90% of those who smoke daily reported smoking meth (see Fig. 8).

Times Smoked Every Day (n=79/40%)

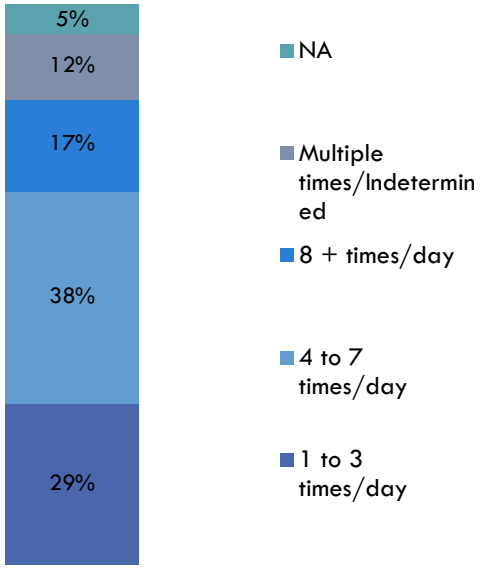

Fig. 8 – Daily smokers' frequency of smoking

Sharing Smoking Devices

As sharing smoking devices is a common practice among people who smoke drugs and that cuts and burns may result from smoking devices are alleged to present a risk for HIV and HCV transmission, we asked participants about their sharing practices. Reducing the practice of smoking equipment sharing is a main goal of safer smoking devices distribution programs.

About a **quarter** of (24% - n=47) respondents indicated **not having shared a pipe with anyone** in the past month. Among those who shared their devices, **over three quarter (76%) did so with people they know. Thirty percent shared their devices with people they do not know** (Fig. 9).

Over **88% of those who smoked daily indicated sharing their pipes with someone they know.** 40% did so with someone they did not know.

These findings continue to reflect evidence from other studies that suggest that sharing devices is part of the group sociality.[3] We observed a slight change in smoking equipment sharing as shown in the Street Connections/ Outreach Services program monitoring and evaluation conducted in 2013-2014. At that time, 32% of respondents indicated not having shared their pipe, and 68% having done so.[4] Current data seems to suggest that more people are potentially sharing their pipes. This comparison raises questions on what and how smoking devices are shared and under which circumstances. Further, it also raises questions about the type of interactions during distribution of smoking devices at harm reduction supply distribution program.

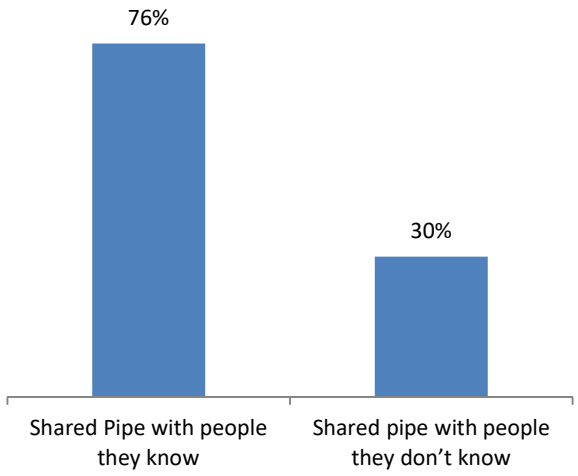

Fig. 9 – Participants' sharing of smoking devices

How drugs were smoked

Most respondents indicated using more than one type of smoking device. The wide range of devices named reflects in part the wide range substances smoked, and availability of the devices at any given time. Three quarter **(75%) of respondents would use a straight glass stem. Sixty-eight percent would use a bubble pipe, followed by half who would use a modified bubble pipe made from a glass stem.** Over a quarter would use aluminum foil, and only 6% would heat up their drug in a cooker to smoke the fumes through a glass stem (see Fig. 10). Additional devices were mentioned, most fitting a broad category of "do it yourself." Notably, other than for those mentioning the use of light bulbs, "hot rails," or "brillo" most other methods mentioned were more likely for smoking cannabis (e.g., paper, bongs, metal pipes, "hot knives").

[3] See Hunter, C., Strike, C., Barnaby, L. *et al.* (2012).Reducing widespread pipe sharing and risky sex among crystal methamphetamine smokers in Toronto: do safer smoking kits have a potential role to play?. Harm Reduction Journal 9:9. Seear, K., Gray, R., Fraser, S., Treloar, C., Bryant, J., & Brener, L. (2012). Rethinking safety and fidelity: The role of love and intimacy in hepatitis C transmission and prevention. *Health Sociology Review*, *21*(3), 272–286; Shaw, S. Y., Shah, L., Jolly, A. M., & Wylie, J. L. (2007). Determinants of injection drug user (IDU) syringe sharing: the relationship between availability of syringes and risk network member characteristics in Winnipeg, Canada. *Addiction (Abingdon, England)*, *102*(10), 1626–35.

[4] Ross, C (2015). Street Connections/Outreach Services Program Monitoring and Evaluation Report. Wpg: WHRA.

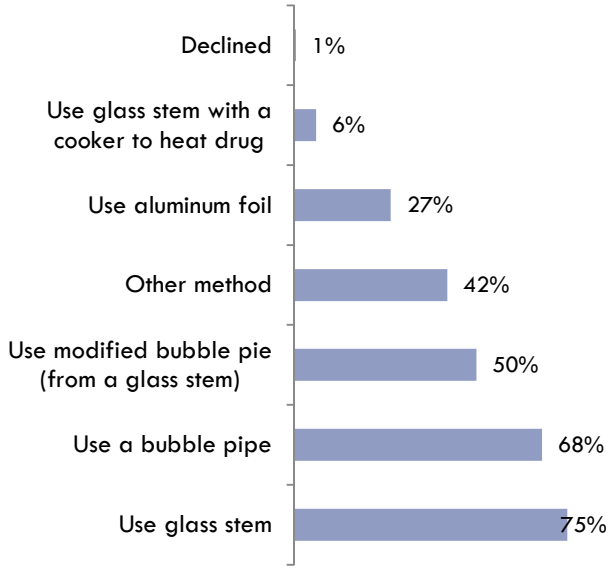

Fig. 10 – Type of smoking device used

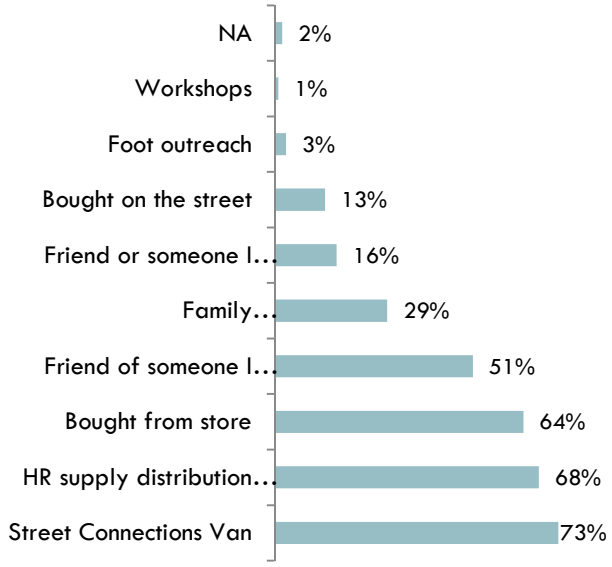

Fig. 11 – Participants' access to smoking devices

Where do people got their smoking devices

About three quarter (**73%) of the respondents would get their smoking devices from Street Connections van**. Sixty eight percent would do it through fixed harm reduction distribution services. **A large number (64%) would also buy their pipes from a store**. About half would also get them from friends or someone they know, followed by about 30% who would get them from a family member or intimate partner. Some would buy them from a friend or someone they know (16%) or directly on the street (13%) (See, Fig. 11).

When compared to the entire sample, **those who smoked crack appeared more connected to harm reduction services, both mobile and fixed sites** (e.g., 80% sought supplies from Street Connections van vs. 73%; and 83%, from fixed supply distribution sites vs. 68% respectively). This may reflect the long-standing availability of Safer Crack Use Kits (SCUK) in Winnipeg via harm reduction supply distribution sites.

Those purchasing smoking devices from stores indicated paying as little as $2 and as high as $30 per device.

Most of those who obtaining smoking devices from friends or someone they know (n=25) at a cost would pay between $2 and $20. A few respondents would exchange cigarettes or drugs, or glass stems for (other type of) smoking devices (n=7).

This was similar to the case of people who would buy their devices on the street. Most indicated to pay between $2 and $50 (n=24). Although for the most part, people would pay around $5. A few indicated trading drugs for the device (n=4).

Main sources of smoking devices

Although numerous participants had purchased smoking devices in local stores, **the main source of smoking devices were harm reduction supply distribution programs**. Near 60% of respondents would mainly get their supplies from harm reduction programs. And although 64% would buy devices from stores; 27% indicated that their main

source of smoking devices were stores. An additional 13% would get their devices from people they know (for free) (see, Fig 12).

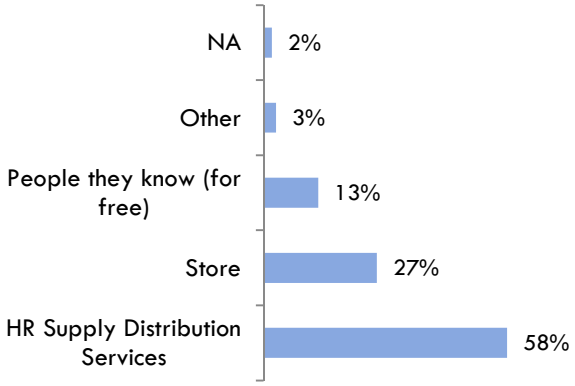

Fig. 12 – Places of access to smoking devices

How easy is it to get smoking device?

In order to understand accessibility to smoking devices respondents were asked to rate how easy it was for them to access a smoking device. As illustrated in the chart below, over half of the participants said that it was "easy" to get a hold of a smoking device, followed by 32% who said to be "very easy." Twelve percent found it "hard" or "very hard" to find something to smoke their substances.

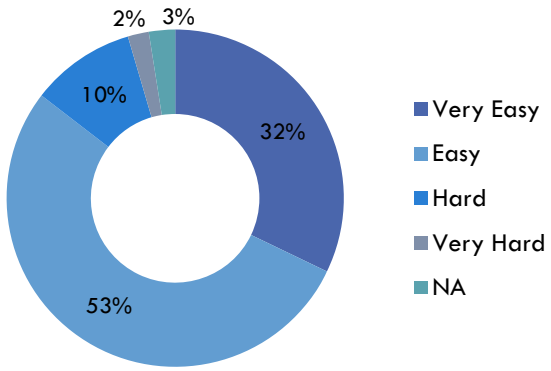

Fig. 13 – Assessment of accessibility to smoking devices

Overall, there was not difference between males or females in terms of easiness of access to smoking devices. However, more males indicated that it was "very easy" than females; while more females said that it was "easy." The same proportion of males and females (about 10%) found it "hard" and "very hard." However limited by the small data available, similar patterns emerged in relation to people who identified with another gender identity or as Two –Spirit.

In a nutshell,…

- **After cannabis, 77% of participants smoked methamphetamine.**
- **58% of the respondents smoked crack.**
- **40% smoked every day, multiple times a day.**
- **24% respondents indicated not having shared a pipe with anyone in the past month.**
- **Among those who shared their devices 76% did so with people they know.**
- **30% shared their devices with people they do not know.**
- **75% used glass stems, 68% used bubbles and 50% used modified bubbles (made from glass stems)**
- **73% got their smoking devices from Street Connections van; 68%, from fixed harm reduction distribution sites, 64% bought their bubbles from stores.**
- **People who used crack would more likely get their supplies from a harm reduction supply distribution site than those who did not smoke crack.**
- **53% of participants indicated that it was "easy" to get a smoking device. 32% said it was "very easy."**

EXPLORING THE RELATIONSHIP BETWEEN SMOKING AND INJECTION DRUG USE

To help us elucidate the relationship between smoking and injection substance use, we inquired on the type of drugs, and length of injection, as well as the impact that access to smoking devices may have on injection drug use.

Over 60% (n=122) of respondents had injected drugs in the past 6 months. The following chart shows the gender distribution of those who only smoke or smoke and inject substances.

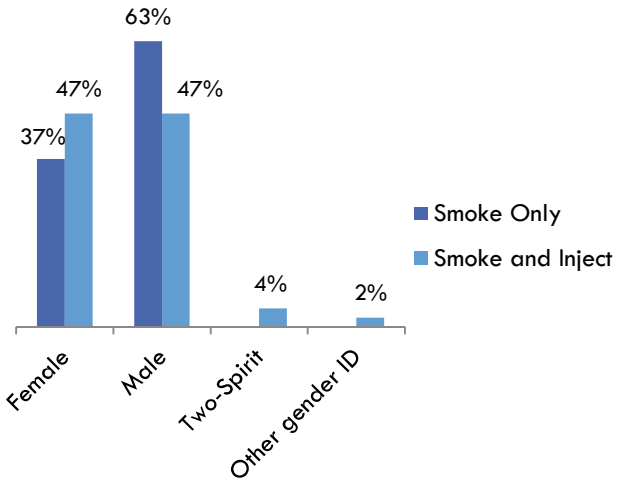

Fig. 14 – Substance use practices by gender

At 47% respectively, **the proportion of males (n=57) and females (n=57) among those who smoked and injected was the same**. All participants who identified as Two-Spirit or non-binary gender identity (n=8) smoked and injected substances.

With **almost everyone** (96%) injecting **methamphetamines,** this was by far the most common substance mentioned. At a distant 24%, morphine was the second most used substance. 22% used Dilaudid. However, as shown in the graph below people had injected a wide range of other substances in the past 6 months.

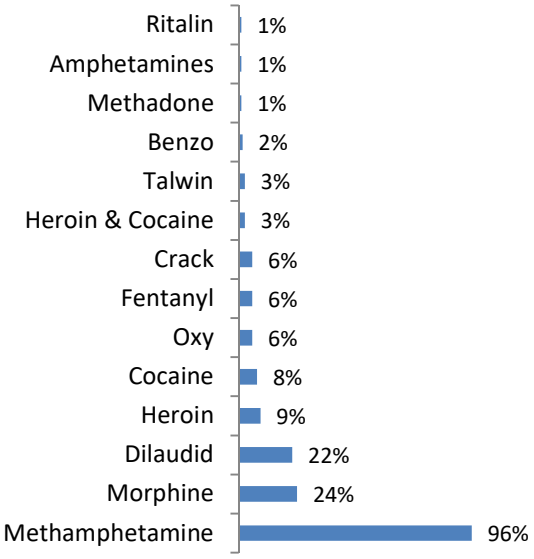

Fig. 15 – Drugs injected in past 6 months

62% of those injecting meth had only injected meth. The rest had also injected other drugs. **95% of females used meth** (only 3 females did not use meth). The rest used cocaine, crack and heroin/morphine, respectively. And **68.5% of females only used meth.** 21% also used morphine, and 17.5% also used hydromorphone/Diluadid. Similarly, **95% of males used meth. 63% only used meth.** However, a **higher proportion of males had used morphine (26%) and hydromorphone/Diluadid (28%)** when compared to female respondents.

Length of time injecting

Respondents had been injecting for a wide range of time. Participants reported having been injecting for as little as 2 days to up to 35 years. Still, **47% had been injecting for less than 2 years**. This was followed by a quarter of respondents who indicated having been injecting for 3 to 5 years. The rest was very much split between 6 to 10 years and over 10 years.

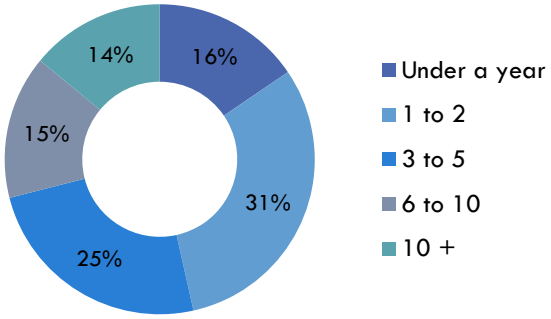

Fig. 16 – Length of time injecting drugs

When we looked at the gender distribution, the same number of males and females had been injecting for under a year, with a slightly larger number of females in the 1 to 2-year category (i.e., 35% vs 30% respectively). Conversely, slightly more males were found in the 3 to 5-year category (i.e., 26% male vs. 19% female). Although small in numbers, half of those who identified as Two-Spirit or gender non-binary had been injecting for less than a year (n=4).

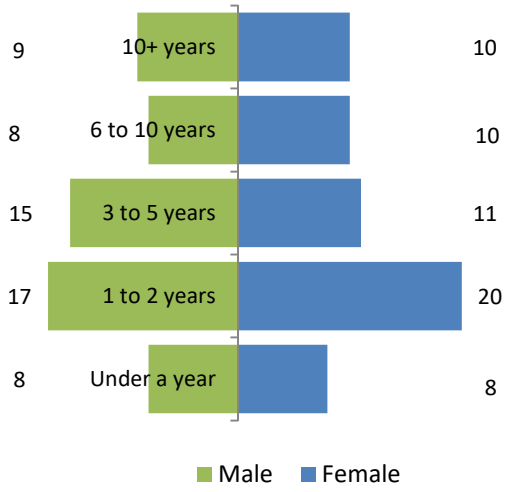

Fig. 17 – Length of time injecting by gender

Impact of smoking supplies on injection

We asked participants what they usually did whenever they did not have a smoking device at hand. This question was open-ended. Responses easily led us to distinguish a few clear categories. **42% would use the substance through a different route**, followed **by 40%, who would look for other smoking devices**. 14% indicated that they would prefer to wait till having access to a smoking device. A few would actively seek out a device.

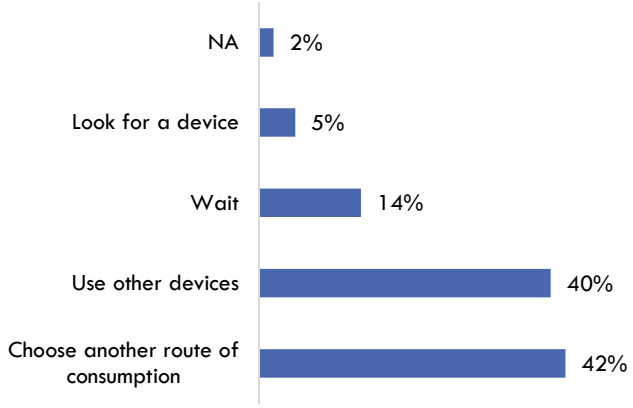

Fig. 18 – Participants' actions when no smoking device is available

Among those who reported using another route of consumption, 71% would inject. Over 41% would snort and only a few would ingest the drug. Some of the respondents mentioned more than one route of consumption.

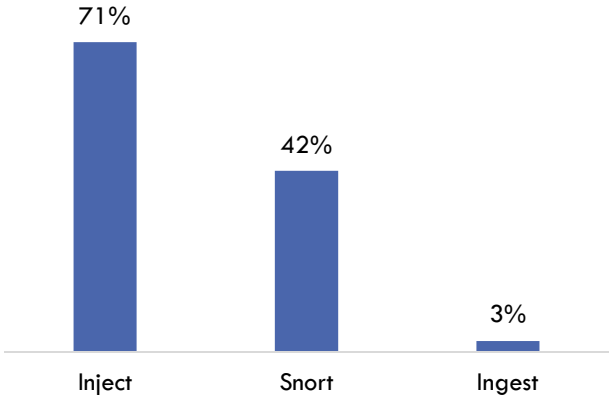

Fig. 19 – Alternative route of consumption

Two-third (66%) of respondents who injected reported that **access to smoking supplies did not have any impact on their injection practices**. Still, when we asked what people would do when no smoking devices were readily available, about **half indicated they would inject**. Some of these would also snort their drugs or make something to smoke them. Overall for over 75% of these respondents, it was "easy" or "very easy" to find something to smoke their drugs. These findings suggest that injection and smoking would be related to other matters, not to the assumption that the lack of a smoking device would necessarily lead to injecting.

Of the remaining **one third**, their responses varied widely. Several participants (n=12) suggested that the **lack of access to smoking devices would somewhat facilitate or lead to injecting their drugs**. However, in only a few cases this appeared to be the leading cause for injecting (e.g., "it is easier to get injection supplies," "yes, I have to pay to buy a pipe but cleans are free"). On the other hand, many people surveyed would **prefer to inject anyway**, as "injection is a better high" or "because smoking is too expensive" or "I use less when I am injecting." These responses suggest that cost-effectiveness, cost-efficiency or other considerations surround drug consumption.

Several participants mentioned that **access to pipes helped them manage their injection**. For instance, a person would inject once a day and then smoke to maintain their high. In the same vein, others would say that smoking had "slowed down" their injection. Others would prefer smoking to injecting as result of ill-effects of injection.

Perspectives from qualitative Interviews

Ten participants came forward for a qualitative interview over a two-week period in February 2020. There were 4 who identified as female and 6 as male. Most of them resided in Winnipeg's inner-city – only one had recently moved out of the core, but was still requesting harm reduction supplies from HSHR. All participants were polysubstance users but currently using methamphetamine for the most part. One of the participants said to be mostly using opioids and another person indicated to only smoking crack.

Context for using substances

Although not intended to delve deeply into participants' histories of substance use, many disclosed personal and social hardships surrounding their initiation and ongoing use. These included desires to "forget" or "deal" with past or current relational issues in their lives, deal with depression or stigma, obtain a state of "euphoria" or better sexual experiences. Some did also shared how they managed their substance use and their struggles with trying to quit, and access treatment services. Much of these stories revealed profound stigma and discrimination in the context of social services and healthcare systems. Disruption of family ties, limited social supports, and loneliness resulted from encounters with institutions, greatly influencing the way participants related to substances.

> **I smoke it, needles, whatever. It wasn't till…I used to be straight, and I lost my family [to child welfare intervention], so I needed something to cope, and a friend said, "have some of this, it will take all the pain away." And 3 years doing it makes me numb, numb, you know? Just numb, helps me not dealing with my feelings. (Male, mid-30s)**

> **It would help me deal with my depression. But, man, when you want to come off it, oh man, a ball of tears would come out. (Male, mid-50s)**

> **I use it to forget. I use to forget. Basically, I use it to forget lots of things. I have seen a lot of stuff in my life. For that specific reason, it is**

good. When I am stoned I don't think of anything. It is just my mind. I know that this drug is basically mind free. (Male, early 30s)

Effects of substances through different routes of consumption

The way substances were consumed depended on the social context of participants' lives as much as of availability of harm reduction supplies, both for injecting and smoking. Where and with whom participants were would shape how drugs were consumed. Most participants would consume substances in many ways. However, injecting was prominent. Participants had come to injecting through offers made by friends or others in their social circles. Although for most smoking was secondary; this practice was also dictated by the social context.

The effects (high) of the substance were highly relevant to how they would continue or prefer to use. With immediate desirable effects of "euphoria" or "rush", injecting drugs was preferred to smoking or other routes of consumption.

Rig. Injecting is more…it hits you like that! You can smoke and don't feel nothing (…) It is not the same. (Male, mid-30s)

If you smoke, it takes lots to get high, I find. But when you inject you don't need that much. People, I think, would prefer to inject, but it also would be up to the individual and the people around you. (Female, mid 20s)

I am not much of a smoker myself, but if I don't have a syringe around I would smoke it. It seems that it takes way longer to get high of it. (Male, early 30s)

Injection is best, and the bubble it is horrible! If you do bubble you get scared a lot. Oh-oh, God [is] talking to me! (Male, mid-50s)

Straight to syringes. The way I see it, it takes too long to smoke. It is better. It is faster. When I want to get high, I want to get high. That is basically it. (Male, mid-30s)

As also revealed in the survey, participants would conduct some sort of calculations based on what they "get" from the substance or what the substances "give" them. In today's strong meth market, meth provided a cheap and effective high. Still, most explained how they moderated their use to prevent harmful effects.

If I didn't have a rig I would snort it, you know. But every high is different, different high if you smoke it, snort it or shoot it, you know. It is all different. But I don't, I don't exceed, like I don't do a 4 point shot, I do 1. I keep it balanced. I do it just once (…) one hit can be for 5-6 hours, 8 hours and you come down and you sleep, you get hungry. (Male, mid-30s)

Harms associated with substance use

Health Concerns

Interview participants shared some of their concerns about substance use. Repeatedly participants described their preoccupation around overdose. This is something they had experienced, have dealt with or observed among people in their social networks. Participants understood that overdose could occur through different means of consuming their drugs.

I overdosed, overdosed! [It was] 6 o'clock in the morning, my street brother called me, I opened the door, I let him in, gave me a blast on a

bubble, I took two blasts. I felt so… like lost. I blacked out on the sidewalk (…) They put me on a [shopping] cart and they pushed me to a soup kitchen, a soup line. Straight blackout. They called paramedics, came pick me out to the hospital. I slept 14, 16 hours. (Male, mid-50s)

Some of the participants would also describe common health concerns associated with using meth such as not sleeping for days, or lack of food or nutrition for long periods of time.

And after 3 days you feel tired. I just did a little, half a point shot and couldn't sleep for 3 days. (Male, early 30s)

Paranoia and auditory hallucinations were also described by some of the participants.

Recently, a couple of days ago I'd been up for 4 days, I started hearing "hey, pst!" There was nobody there but once in a while I would say "fuck, leave me alone" because I hate when I hear "hey, pst, hey!" I don't know what that is or I have been out too long. (Male, mid-30s)

I have less problems when I am by myself. When you hang with a crowd, people may think that you are in a gang or approach me. So, most of the time, I am by myself or walk around. (Male, late-30s)

Aware that infections could be easily transmitted through the sharing of injection equipment, some participants were concerned about HIV transmission. These comments were only associated with injecting practices rather than smoking. In addition, participants who injected meth indicated not "cooking" their drug (dissolving it in sterile water and heating the drug) – even when they would think of the drug as "dirty."

Additionally, no concerns were raised around the use of makeshift bubbles or other methods of smoking. Notwithstanding, one participant talked about harmful effects of smoking meth on his lungs.

Social Harms

Most of the substance-use related harms participants described concerned their social environment. Participants illustrated many personal experiences with violence towards them or around them, interpersonal stigma directed at them, institutional racism, and the lack of spaces where safely use substances. Some of the stories were directly related to institutions such as the child welfare or justice systems.

They think that they did this, their problem. We are all the same. We are no different than anybody else. It takes that one person that keeps you down (…) It is sick, what people say, what people do. They keep you, do stuff, not physically, but emotionally, mentally, they get inside, and think that they, they push you down and you start to think, to believe in that, oh yeah I am a bad person, these people tell you, you are dead, you are shit, you are living in hell, you know. Don't believe that. It is bullshit. (Male, mid-30s)

One of the participants described at great length how he would closely monitor how he presented himself on the streets to prevent acts of discrimination based on assumptions of drug use.

I don't want to be treated the way they treat the other ones. Like some drivers the call behind you, and drive a little fast if they think that they are suspecting you are high, honk their horns and all that stuff. I just ignore a lot of stuff. I just ignore everything, ignore everybody and just do my own thing. I never look back. I never look back. It bugs me. It really fucking bugs me. I always tell people don't fucking look back, because we are going to get busted. (Male, early 30s)

Sharing Equipment

As reducing sharing of smoking devices is a major driver behind the distribution of smoking devices at harm reduction supply distribution programs, we inquired on this matter.

Some participants understood that they should not share their devices to prevent the transmission of infections. Others would not share to keep each ones share of drugs in check – sharing a pipe would also means that drugs were shared, something that participants were very concerned about.

> **I smoke by myself. I don't share my [pipe]. I don't like to share my drugs [laughter]. When I don't know the people, I prefer to keep it out. (Male, mid-50s)**

> **Well, they say don't get high by yourself. I try to make sure that I have a friend with me. But I never share my [harm reduction] supplies. If they don't have their own supplies I give some to them, but I don't share my supplies. And specially with smoking my bubble, I make sure that they have their own pipe. (Female, mid-20s)**

Some indicated that they would make sure that people had their own devices. However, the social circle would greatly influence whom people would smoke with, including pipe sharing. As suggested in the analysis of survey data on this matter, sharing of smoking devices is pervasive or inevitable under certain circumstances.

Access to Smoking Equipment

Access to smoking equipment was not hard for any of these participants. As reflected in the survey, participants would buy "bubbles" (i.e., glass stem with a bowl attached) in local stores or would blow them out of straight glass stems they get from harm reduction supply distribution services. One of the participants described "hot railing," a technique by which a glass stem would be heated while inhaling a line of vaporized meth as another major way in which meth was inhaled in his social circle.

Despite easy access, participants suggested that it would be helpful to have devices for those who smoke meth available to those who cannot afford them. One of the participants also indicated that lack of free "bubbles" at harm reduction services would also force a choice of how to use their drugs.

> **It is only 5 buck, but they break. Some people, they can't afford it…they can't get a bubble. It would be nice to have to have access to bubbles. (Female, early 20s)**

> **I think that if they offered bubbles I would [smoke more]. They don't have bubbles, all they have is needles. Sometimes, I don't want to do it, but if that is the only way. (Male, early 30s)**

On the other hand, one of the participants insisted that harm reduction supply distribution services should focus on providing safer injection drug use supplies. This person believed that harms associated with injection drug use were definitely more "real".

> **It is not that there won't be any benefits [to having meth pipes available], but I think that doing needles exchange is very good, very good program because there are people with HIV, for that reason it would keep people healthy. (Male, mid-50s)**

CONCLUDING REMARKS

As result of this assessment we can assert that current drug use is tightly related to a meth saturated drug market. Much of the experiences of using meth transpired in the surveys and interviews. Nonetheless, participants would smoke or inject a variety of substances.

Our data show that sharing smoking devices is a common practice, especially among more intimately related people. Consequently, availability of smoking devices as a harm reduction tool would continue to be limited in addressing the theoretical/potential infection transmission associated with pipe sharing.

For the most part, in Winnipeg, gaining access to a smoking device was easy. Participants would get their smoking supplies from harm reduction distribution services or buy them from stores. Not surprisingly a sizeable number of participants would modify glass stems into bubble pipes for smoking meth, and many would also use stem glass for "hot railing."

We found that injecting meth was preferred to smoking for many. Participants described to obtaining a better high from injecting. However, we also learned that some would smoke meth as a way of maintaining their high from injection. This practice would result in reduced number of injecting episodes. The elucidation of questions regarding the role of smoking on injection initiation (as we assessed many participants had been injecting for relatively a short period, and were also older in age) requires further investigation.

Overall, participants were concerned about other harms associated with substance use than those related to the spread of infections. Social harms clearly marked the onset of drug use for many and these continue to be the main driver of ongoing substance use, and the barrier to quitting.

A limitation of this assessment is that for the most part we engaged with recipients of harm reduction supply distribution services. The experiences of those who do not access these services, and in particular of youth who smoke and inject drugs are not well represented here.

Programmatic or Service Implications

With meth as the most accessible drug in Winnipeg, it is reasonable to see access to appropriate smoking devices as desirable.

To some extent the expansion of types of smoking devices at harm reduction supply distribution sites or programs in Winnipeg will reduce the use of makeshift equipment and saving money. However, it will likely not change pipe sharing practices.

The distribution of safer meth smoking devices may support those who inject and strategically smoke to keep up their high while reducing the number of injecting episodes. This harm reduction practice should also be shared to promote alternative ways of using substances.

The addition of types of smoking devices to the current harm reduction tools would need to take into account:

- Harm reduction strategies for engaging clients who smoke substances
- Exploration of different models or strategies for the distribution of safer crystal meth smoking devices (i.e., bubbles) – e.g., cost recovery/vending machine
- Operational issues for programs with limited capacity dedicated to harm reduction supply distribution.
- Ongoing consultation with people who use drugs – including feedback to this report which was hampered by COVID-19.

These programmatic or service implications are very narrowly defined. However, this assessment also points to broader societal issues underlying populations engaged in harm reduction supply distribution. These matters should continue to guide population and public health approaches and advocacy efforts concerning structural issues affecting people who use substances.

SMOKING SUBSTANCES: A SUMMARY OF THE EVIDENCE

Harm reduction programs distribute safer smoking devices on the premise that hepatitis C and HIV transmission may occur among those who share smoking equipment (e.g., Haydon & Fischer, 2005).

However, studies on hepatitis C and HIV transmission among non-injection drug use point to a lack of evidence on causal pathways of infection from smoking or snorting (McMahon and Tortu, 2003; Porter et al., 1997; Scheinmann et al., 2006). Yet, hepatitis C prevalence among non-injection drug users was higher than among the general population (e.g., Armstrong et al., 2006; Macias et al., 2008).

Smoking crack cocaine was found to be an independent risk factor for HIV seroconversion over time for people who injected drugs (DeBeck et al. 2009). Oral sores have been found to be more prevalent among people who smoked crack (Faruque et al. 1996). However, sores were not necessarily associated with burns from smoking devices.

Research predicted transition to injection initiation among street involved youth from non-injection use (i.e., smoking and/or intranasal use) of crystal methamphetamine (Werb et al., 2013).

Findings from crack kit distribution in Vancouver suggest that the expansion of these services has likely served to reduce health concerns from smoking crack (e.g., decrease in burns) (Prangnell et al., 2017; Vancouver Coastal Health 2013). Other benefits to SCUK distribution were increased personal and community safety (e.g., less petty crime) (Ivsins et al., 2011). Another study showed that SCUK distribution led to transition to safer methods of drug consumption (Leonard et al., 2008).

Other interventions aimed at reducing initiation into injecting and promoting transition away from injecting for those already injecting have shown emerging positive evidence (Ritter et al., 2006). Although price and purity were important considerations when transitioning from injecting to smoking in a heroin market (Dolan et al., 2004).

While safer smoking kit distribution made safer use items more accessible, its impact on safer use practice was found to be limited (Malchy et al., 2011). Sharing pipes had been found to be intrical to the social experience of smoking (Hunter et al., 2012). Further, crack pipe sharing was not associated with access to free or low-cost pipes (Ti et al., 2011).

The harms experienced by people who smoke substances were well beyond infection transmission. Lack of safe spaces to smoke, poverty, unstable housing, police destruction or apprehension of equipment, stigma have been documented in the literature (e.g., Green and Moore 2013; Malchy et al., 2008; Ward et al., 2000).

Notably with a few exceptions, the literature on illicit smoking substances focuses on crack.

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