Harm Reduction From Below: On Sharing and Caring in Drug Use

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Abstract

This article focuses on how recreational drug users in the Netherlands and in online communities navigate the risks and reduce the harms they associate with psychoactive drug use. To do so, we examined the protective practices they invent, use, and share with their immediate peers and with larger drug experimenting communities online. The labor involved in protective practices and that which ultimately informs *harm reduction from below* follows three interrelated trajectories: (1) the handling and sharing of drugs to facilitate *hassle-free* drug use, (2) creating pleasant and friendly spaces that we highlight under the practices of *drug use attunements*, and (3) the seeking and sharing of information in practices to *spread the good high*. We focus not only on users' concerns but also on how these concerns shape their approach to drugs, what young people do to navigate uncertainties, and how they reach out to and create different sources of knowledge to minimize adversities and to improve highs. Harm reduction from below, we argue, can best be seen in the practices of *sharing* around drug use and in the *caring* for the larger community of drug-using peers.

Introduction

Those involved in understanding, using, producing, or regulating drugs in society deal with issues around possible harm. However, how drug-related harm is handled and mitigated differs across various actors and practices—differences that shape the contours of not only what counts as possible harm in drug use but also what drug use is and can be in its varied practices. The values that these drug practices engender inform our conception of harm reduction from below.

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Recent drug scholarship has emphasized the socio cultural contexts in which drug practices emerge and persist, focusing for example on the roles of pleasure (Moore, 2008), solidarity (Kavanaugh & Anderson, 2008), bonding (Foster & Spencer, 2013; Riley, Morey, & Griffin, 2010), trance (Ott & Herman, 2003; Selanniemi, 2003), letting go (Riley, Griffin, & Morey, 2010), ecstasy (Moloney & Hunt, 2011), and spiritual transformation (Goulding & Shankar, 2011; Ruane, 2014). A further trend in the scholarship is the growing focus on the deliberate and strategic use of drugs (Duff, 2005; Hunt, Evans, Moloney, & Bailey, 2009). This trend is reflected in Zinn's (2008) notion of "in-between" strategies that are neither strictly rational nor irrational, where tools that incorporate hope, trust, intuition, and faith produce knowledge and understanding of the risks involved in substance use. Here, "most individuals do not interpret risk as an objective category but live with risk using their culture, available symbols, and their sense of aesthetics to make judgments about what risks to take" (Zinn, 2008, p. 446). Our participants viewed the risks associated with drug use not in absolute terms but as relative, "while unpleasant, they were an accepted or normal part of taking drugs" (Hunt, Evans, & Kares, 2007, pp. 83–84). As Moore (1993, 2010) has pointed out, this does not imply an absence of norms around drug use. The young people who are the subject of this article generally felt a sense of control over their drug-using practices and drew boundaries demarcating acceptable from unacceptable use (Pilkington, 2007a, 2007b), distancing themselves from "misusers" and expressing a "sense of belonging to a preferable group of drug users" (Foster & Spencer, 2013, p. 224).

Mainstream harm reduction policies often overlook the diverse practices in which drug use becomes *valuable* to users.[1] As government officials and health care practitioners deploy discourses of "impermissible pleasure" as a strategy to selectively manage individuals (Bourgeois, 2000; Moore & Measham, 2008, 2012b; O'Malley & Valverde, 2004), the idea that individuals can manage or "self-regulate" themselves in the face of the "negative effects" of drugs is often ignored (Uitermark & Cohen, 2006, p. 185). But young people are extremely creative when it comes to "adjusting dosage and mixing substances, with knowledge of the (mostly positive) 'lived effects' of drugs spreading through collective experimentation and word of mouth" (Hardon & Moyer, 2014, p. 110). Conceptualizing drug use as irresponsible—and reducing the "voice" of drug users to "noise" (Dikeç, 2004)—leads to blunt policies. Harm reduction policies that do not consider the intentions and lived experiences of drug users will most likely fail. Harmful or risky behavior does not adequately describe how many users engage with drugs; it remains an outsiders' perspective tied to particular ideas of control as articulated by government and public health officials.

While previous studies have addressed how people regulate their drug use to reduce potential harm through "micro-social forms of collective self-protection" (Friedman et al., 2007, p. 115), in this article, we focus on specific self-protection techniques, as they emerge in various networks and spaces. Which practices are ascribed as risky and which as worthwhile? How does the practice of mutual care generate norms and values around drug use? How does it affect decisions to share time, money, drugs, events, and party spaces? The practices we analyze in this article show that ascribing risks and mitigating harms takes place within contexts where actors come together to party, to experiment, to care, and to share.

Method

This article is based on joint analysis of the results of four focused ethnographic studies conducted by the authors. Our analysis focused on a common theme: harm reduction from below. The theme emerged at a ChemicalYouth[2] analysis workshop held in Driebergen, the Netherlands, in January 2015. The fieldwork that we conducted for each of the four studies took place in the Netherlands, whereas the virtual community we studied is less geographically bound. Dutch policy takes a relatively tolerant and pragmatic stance to harm reduction[3] (Reinarman, 2005; Uitermark, 2005), with specialized authorities providing test services and education about safer drug use[4] within an overall

gedoogbeleid (policy of tolerance) regarding drug possession and use. This relative tolerance toward drugs in the Netherlands aided our fieldwork. The youths and young adults we talked to felt comfortable sharing their experiences of regulating and optimizing their own drug-taking, handling risky situations, and other risk-mitigating behavior they engage in.

The first author of this article, Inge van Schipstal (I.v.S.), curious about the safety nets provided by friendship groups, conducted research within private after-party circuits in Amsterdam and Utrecht between September 2013 and February 2014. Her group of participants comprised two friendship networks whose members have been partying, visiting festivals, and collectively engaging in polydrug use for 5–8 years. Swasti Mishra (S.M.), interested in learning more about "non problematic" and "recreational drug use," ventured into psychedelic trance festivals in the Netherlands between March and June 2012. She also observed how the dosing of MDMA is discussed in an online message board (Forum X). Hayley Murray (H.M.), interested in the concept of "risk" in relation to drug use practices in risk environments, conducted research between February and May 2014, with recreational drug users attending two Amsterdam techno music festivals. Moritz Berning (M.B.) became part of a virtual drug community and web forum (Forum Y) where he participated in message board discussions and interviewed participants, both online and off line. He conducted his research between February and April 2015. Forum Y is dedicated to the exploration of uncharted designer drugs.[5] M.B.'s participants are referred to as *designer drug experimenters* because they primarily focus on exploring, mapping, and discussing new and uncharted substances (Soussan & Kjellgren, 2014). Pseudonyms are used when referring to all participants in this article.

We conducted in-depth interviews, virtual and on-site observations, surveys, and comment (thread) consultations and studied available personal data. Interviews comprised open-ended questions and were recorded and transcribed. Data in the form of interview transcripts and field notes were subject to thematic analysis (Braun & Clarke, 2006). The findings from our online research on user interactions and values surrounding drug use were triangulated with nonparticipatory online observation on various websites (*lurking*), interactive participatory observation in Forum Y using member profiles, and Skype-based and face-to-face interviews (cf. Barratt, 2012; Barratt & Lenton, 2010; Móró & Rácz, 2013; Soussan & Kjellgren, 2014). We also employed lurking as a method to observe dosing issues on Forum X and performed a simple descriptive key word analysis of communication within Forum Y by scraping the text.

Considering participants may have had reservations about discussing illegal substances, and in order to protect their anonymity, we undertook several measures.[6] Some interviews occurred while participants were affected by drugs, potentially reducing or compromising their ability to articulate responses. On the other hand, the potentially disinhibiting effect of drug consumption may have encouraged participants to respond more freely and openly (cf. Joseph & Donnelly, 2012). The online research raises ethical issues regarding anonymity in the digital age and the potential lack of informed consent (Rodham & Gavin, 2006). At the same time, the chronologically asynchronous communication arguably "eases the pressure of immediate response ... facilitating their reflexivity and deferring cognitive resources to the content rather than the management of the conversation" (Rodham & Gavin, 2006, p. 93). Following this rationale, M.B. informed the administrators of Forum Y about our intentions and status as researchers and attached the information to our user account in Forum Y. The quotations from Forum X and Forum Y are not traceable to the original websites via search engines (see the detailed discussion of this ethical issue in Berning and Hardon's contribution to this special issue). The two quotations that were traceable have been modified as was done in comparable research by Soussan and Kjellgren (2014).

We met many of our participants for repeat interviews and clarified what we understood of their practices of drug use. Repeat interviewing allowed us to compare and contrast participant responses and to follow-up key themes, creating a dialogue between researchers and participants (Bakardjieva & Feenberg, 2001). As mentioned above, the virtual discussions and interviews meant less physical

presence but also more balanced communication, arguably leading to greater research participant autonomy and a "more balanced power relationship between researcher and participant" (Barratt & Lenton, 2010, p. 70).

Besides field diaries and photographs, we interviewed 47 recreational drug users at festivals, 25 regular polydrug-using young adults within after-party scenes, and 7 designer drug experimenters. As far as we could tell from our on-site research, most of our participants were from Western Europe and had middle class backgrounds. They ranged in age from 18 to 34 years and included students, workers, chemists, and temporarily unemployed persons. We began by scanning our material for practices to handle substances and minimize risks, grouping them under the following themes: meticulous *dosing*, deliberately choosing and adjusting *settings*, *balancing out* harmful drug effects chemically or through testing, *taking care* of each other, and *companionship*—sharing and handling risks together as a group. What follows are excerpts from our ethnographic data that highlight how youths practice *harm reduction from below*. We further delineate *how* harm reduction from below can be understood as an aspect of self- and peer-made protective practices imbricated in the event of drug use.

On Hassle-Free Highs

While drug use is often portrayed as dangerous, we found our participants took extreme care to foster drug-related highs that are, simply put, *hassle-free*.[7] Practices included determining the "right dosage," tracking intake time intervals, experimenting with "low-risk" drug combinations, taking health-boosting nutrients, or pursuing all of these strategies together.

Taking meticulous care of substance dosing was high on our participants' agendas. Within the various spheres, being *knowledgeable* about dosage and actively sharing and maintaining these norms was appreciated by peers. Young users often stressed that they wanted to keep it "fun," and one way of assuring that the party remains *hassle-free* was being attentive to dosage. Heleen (27 years), christened "Mama G" by her fellow users for the role of caregiver she assumed at after-parties, explained how she and her friend Piper managed the overdose risk associated with party drug GHB or "G" (gamma hydroxybutyrate).[8]

> Whenever we had a bottle of GHB at a party and we wanted to share it with people and people had drunk alcohol ... we tried to prevent offering GHB to those people, or ... people taking [a new dose] too fast after the previous one. We made schemes for that: everybody had to note the time on which he had taken [it] and how much he had taken ... and then we checked for example: "Eh Libby, did you wait for two hours? Is it time to take one again already?" And ... oh yeah, that was also quite funny, because then ... every time ... it became some kind of a game at a certain point ... that people came up to me like: "Eh, can I get some, can I get some?" And then I looked in the scheme: "No, no you can't have some yet, you have to wait for another half an hour."—"Oh okay, okay." (Interviewed by I.v.S., February 2014)

Figure 1 shows Heleen's logbook: the concealed boxes list the names of the people present at the gathering and are followed by the amount of *G* (in milliliters) she served them and the time of ingestion. The words in the upper left corner "Ver-G-Tabel"—freely translated as "For-Get-Table—hint at the difficulties of "timing" GHB. While the dosing itself is easily controlled through the use of pipettes or "tubes" (see Figure 2; measuring as much as 5 ml), estimating the time between doses is more difficult for many users as the drug is experienced as producing a drowsy, woozy effect. Heleen's system prevented her fellow users from overdosing during numerous after-parties.

Another way of tracking time intervals to prevent overdosing was explained by Anne (24 years), a regular in the private after-party circuit. Whenever she uses GHB, she first finds a friend who is also using; whenever she takes a portion, she calls her friend's phone and lets it ring once. Whenever she is
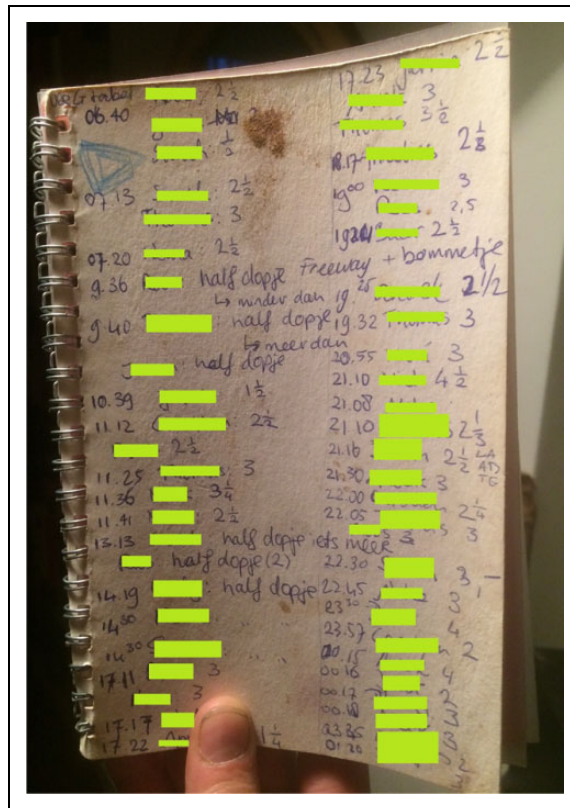
Figure 1. Gamma hydroxybutyrate (GHB) logbook kept by Heleen at an after-party (photo by Inge van Schipstal, April 2014).

Figure 2. Dosing gamma hydroxybutyrate (GHB) with a pipette (photo by Romy Kaa at an after-party in Utrecht, December 6, 2013; Romy Kaa is a Berlin-based photographer who took part in the ChemicalYouth Project by both portraying the participants of Inge van Schipstal's (I.v.S.) research and producing atmospheric images while they were partying. She became involved in the group through I.v.S. and is familiar with the techno party scene herself).

Figure 3. Milligram scale to measure designer drugs (photo by M.B., March 2015).

thinking of taking her next dose, she can check her friend's phone to know when her last dose was—an example of how phones can have agency within the drug event.

Very experienced drug users pay extra attention when introducing peers to a new substance. Administering drugs on the basis of body weight was another protective practice we came across among experienced users. With over 12 years of experience using drugs, Dennis (29 years) was in charge of sharing the drugs, preparing dosages for his friends in accordance with their weight:

> So, here we go! I am going to measure the exact dose of MDMA for everybody. One by one you can tell me how much you guys weigh and the rule of thumb basically is 1.5 times the bodyweight.
>
> Lotte, at this point mentions that she had heard 150 mg is a nice dose for "tripping" and to this Dennis replies: "You probably don't weigh more than 40 kilograms. There is no way I'm giving you 150 mg. You should be good within, eh … let me think maximum 70–80 mg, trust me you will probably feel a lot. And you know you can always take a little more if you don't feel anything." (Fieldnote by S.M., May 2012)

While Dennis' diligence in asking everyone's weight and measuring drug dosage accordingly was appreciated by his friends, we found that in the practice of measuring, there can never be enough *precision*. We found the practices that make up "good" drug use can always be improved, often using new technologies. Designer drug experimenters often used a milligram scale to weigh the substances they planned to use, such as seen in Figure 3. Khan, an experienced designer drug experimenter, explained:

M.B.:   I also think like most scales have a certain error tolerance …
Khan: Not mine, I have a 0.0001-mg scale because that is just too dangerous with some substances. Very important, e.g., with DMT [Dimethyltryptamine]. If I do substances which are really

Figure 4. Example of a flow toy—a "spiral"—bounced back and forth between after-party participants (photo by Romy Kaa, Utrecht, December 6, 2013).

>
> potent I go to a friend who has a professional laboratory scale, you need to turn off the music because the bass will fuck up the measurement. I want to be very careful with that. (Interviewed by M.B., March 2015)

In the above example, the company of friends and good music takes a backseat to the measuring process—the reliability of which, for many designer drug experimenters, informs the decision to ingest a substance or not.

What was considered the "right dosage" by our participants was to some extent shaped by their understanding of the pharmacology of drugs, which was based on information extracted from online forums. They examined pills in different ways, testing for substance *quality* or *purity*. The following discussion on Forum X shows how users reach out to their peers to practice informed, careful, *hassle-free* drug use:

> [Forum title:] Dosing crystals.
> Sa Jul. 13, 2013, 3:39 p.m.
> Hi everyone,
> I got crystals for the first time, (brown and tested on 81% [pure MDMA]). How shall I dose this? When they test pills, they test the amount of pure MDMA that is in there? So let's say there is 267 mg 65% MDMA in a pill then this will be tested as 200 mg MDMA right? (87%) So when I'd start with a dose of 120 mg pure MDMA, I'll have to take a little bit over that 120 [mg]? (Forum X, retrieved March 2015)

The information on such forums, although valued, was not always accepted. Forum participants critically examined drugs for their dosage, quality, and purity, reflecting the concerns of the wider drug-using community about their uncertainties.

> In virtual communities, I often see beginners asking what an ideal MDMA dose might be, and usually the answer is the old 1.5× bodyweight formula. I read that this is based on clinical trials with MDMA and since these are usually on the safe side regarding dosage, I was wondering how much this clinical dose differs from recreational doses. I have never seen any data on how much people actually take so I made this survey [link]: So thank you to everybody who filled it out, you can ask me questions down below. If you are aware of your normal dose please take a min to fill it out cause the more people fill it out the better the data gets. I hope this can be a source for people who discuss their dosing but it would also be great if people could rethink what a normal dose is and how much they take. So thanks to everybody for participating! (Forum X, retrieved June 2012, modified by M.B. to safeguard participant anonymity)

In the realm of designer drugs, we see an even stronger emphasis on cultivating micro-practices that try to minimize harm. This is based on the understanding that most designer drugs are pharmacologically unexplored and highly potent—measured in milligram (mg) or even microgram (μg)—and that the risk of mislabelled substances or allergic reactions is severe. Our participants often approached new designer drugs through "how to" guides that covered, among other topics, the necessary "state of mind," how to measure dosages, evaluate risks and benefits, and the ethics of reporting. An example of such a micro-practice is "allergy dosing" to avoid the risk of a potentially fatal allergic reaction. Baloo provides measuring advice to his peers:

> Measure out approximately 5 mg of your material . . . . Dissolve your 5 mg in 1 liter of distilled water and allow to go into solution. Your solution should now have a concentration of approximately 5 μg/ml. Measure out 1 ml of water and hold it in your mouth for 5–10 minutes to see if any reaction occurs. If not, swallow and wait 1 hour to see if any reaction occurs. If no reaction has occurred, repeat the same operation with 2 mL of water. At the end of that hour repeat with 5 ml of water. This can continue along until you reach a level where you are satisfied that you will not have an extreme anaphylactic reaction. Ideally you probably would want to go up to about 1/10th of an active dose or so. The amount required to do this will of course depend on the compound in question and its presumed active dose. (Baloo on Forum Y, retrieved April 3, 2015)

Our participants compared their methods to those of Albert Hofmann (2009) in his first intentional trial of LSD in 1943, which was to begin with the smallest amount that could have a psychoactive effect. Without knowing the potency of LSD, Hofmann accidentally took a "medium" dose of 250 μg. Amateur pharmacological engagements thrive on a plurality of sources of knowledge. Some of our participants advocated a further cautionary step, to begin with doses "lower than the effective dose" of any substance or substance group known today, including hormones that can be effective at a dose of as low as 12 μg (Lee & Zhu, 2013, pp. 9–10). "Doing it better than Hoffman" has become part of the labour of navigating uncertainty and it is in this process that scientific (rather than drug use awareness or policy oriented) knowledge enmeshes with non-scientific user practices.

Besides measuring, particularly what can be seen and counted, other sensorial registers interact with user preferences. The shape and texture of pills were sometimes as important as measuring and calculating dosages. Natalie (27 years) talked about her preference for ecstasy pills of a specific shape which made it easier for her to bite off even parts in order to track how much she had taken.[9]

Natalie: I'm like, I know *Supermans*, I don't like them because they are [a] triangle, so it's hard to
            . . . [mimes biting].
H.M.:   You mean you don't know how to dose a triangle evenly?

Natalie: Yeah. So, that's why I came up with *Dominos*, because they are the follow up of the *Supermans*, and then I looked it up on the Pill Report [an online drug forum] which I do sometimes ...

H.M.:   Do you tell the difference based on the shape of the pill, or the color or ...

Natalie: Yeah, both. Because I know the *Supermans* are, like, triangles, and they are very nice, the dosage is very nice, but I can't bite if off, because ... I prefer a round pill because you can bite half and then it's in quarters. (Interviewed by H.M., May 2014)

This self-taught technique shows how one participant makes her drug use less prone to hassles by choosing substances with particular qualities—in this case, a circular pill.

Other techniques employed to make drug use worthwhile included "balancing out" exhaustion after taking drugs, dancing, socializing, and not having eaten for hours. "Balancing out" involves strategically combining over-the-counter food supplements and vitamins to mitigate the negative side effects of drugs. Some of our participants took magnesium pills before taking amphetamines, which were said to reduce unwanted and uncontrolled jaw and mouth movements. Special "repair kits" containing a combination of supplements were also promoted in peer networks to alleviate post-drug dips. More experienced users also worked toward minimizing MDMA-induced serotonin depletion by taking 5-hydroxytryptophan or L-tryptophan before and after MDMA use (cf. Dilkes-Frayne, 2014). Post-drug dips were also handled by doing relaxing activities such as yoga, going swimming, cooking for each other, and staying together as a group.

Drug Sphere Attunements

The attunement of the drug use sphere takes place on many levels: adjusting the physical space for maximum comfort (e.g., using pillows and mattresses at after-parties),[10] collectively constructing the environment for optimal audiovisual effects (e.g., dimming the lights while tripping, playing soothing music, and projecting psychedelic videos), wearing comfortable clothing, and bringing tools to enhance or maintain a good ambience or to keep users in a "flow" (the so-called "flow toys" as shown in Figure 4 like spirals, Hula-Hoops and Poi,[11] handicraft materials, and musical instruments). What matters is the creation and maintenance of a pleasant and comfortable environment for getting high. Akela reflects upon the ideal setting for using a designer drug for the first time:

M.B.:   How do you guys prepare for such an experiment? What is a good setting?

Akela: In a nice comfy environment with people you love and at your home. If you like other types of trips you can also go to the countryside, out in nature. There you can mediate or take a walk to calm yourself before it begins. I and many friends actually love the sounds of the animals in the forest, that whole wide open environment. I think that is something that helps to find inner balance and peace. You can even take a walk and train yourself to let go of anything like negative patterns of thinking. But in the end everybody is different so do whatever you need to get rid of the anxiety before you come up. (Retrieved April 2015 from Forum Y, modified by M.B. to safeguard participant anonymity)

The interaction of users, drug practices, and spheres of use leads to different kinds of highs. For instance, *losing control* (as in the instance below) can be deliberate and controlled by delegating care to surrounding persons.[12] Nina (23) stated to her best friend at a psychedelic festival:

Tonight I want to test my limit of sanity, I want to try and go crazy and come back and see how this world looks like, I am going to try at least double the dose of LSD I have taken, and maybe a little bit more. And

then come down with MDMA. You be here with me OK? I will take stuff to draw, braid and maybe poi, yes poi, that will get me into a good flow, even when I completely lose this reality.

In this drug event, Nina's wish to test the limits of her sanity is rendered less risky by ensuring that a friend is with her, by bringing material that will keep her in the flow, and by taking MDMA toward the end of her trip so the "comedown" is "friendlier."

Within a drug trip that lasts for hours, the technique of "balancing out" can be extended in time and place. A trip to the supermarket and preparing and receiving a meal is rewarding for all those present, as Jesse (26) explained:

> It's usually me who takes on the mission of cooking a meal for everyone. You can tell it is time for that when people start getting tired and … their energy levels drop. People just need food you know! Especially when you skipped a night's sleep … you can't get energy out of sleeping then, so you definitely need to eat properly.

The collective eating and preparing of a meal at an after-party functions as a protective practice to reduce harm, replenishing party goers' energy and stamina and providing a communal atmosphere that nurtures care and social control.

Lenardo (27 years), one of I.v.S.'s participants, compared prolonged polydrug use at after-parties to mountaineering—both being extreme activities that require perseverance, collaboration, endurance, and training. The difference is that for drug use, there are no official certificates or liability waiver forms. Many of our participants compared informed recreational drug use to risky or "edgework" practices (Lyng, 1990) such as skydiving or mountaineering under the guidance of trained professionals.

The ongoing discussion around when official/professional/expert guidance counts for those it targets is not limited to drug use. One of our participants, John (28 years), compared official advice on drug use to travel advisories, where large swathes of territory are deemed unsafe due to the risks of kidnappings, shootings, or civil wars. But John and many of his friends have to such places, distrusting official guidance and relying more on backpacker blogs.

Spreading the "Good High"

While many of our participants only used drugs several times a year, many spent more time writing "trip reports," updating, discussing, and informing people about the "good" and "bad" kinds of drugs and forms of use. Spreading the good high entails sharing information about bad highs—to create norms around "what can be done" and "what should never be done or experimented with." Sharing knowledge within the peer group is a crucial part of young people's strategies for collective self-protection. For our participants, this flow of information—spread by word of mouth or through Internet forums—was the primary means to get informed and stay up-to-date with developments in the drug scene. These include changes in the composition of new batches of pills or trip reports of experienced *psychonauts* teaching less experienced ones. The so-called *tales of caution* are published in the designer drug forum to warn other users about specific substances or combinations of substances. One of our participants wrote such a tale of caution about his flubromazepam[13] experience in which he made several near-fatal mistakes:

> FLUBROMAZEPAM! VERY POWERFUL SUBSTANCE
>   Due to my false calculations with this potent drug, I experienced a horrible series of events. It was my bad.

I came home and met my roommate who said there was post for me. I received 1 g of flubromazepam. I explained a little bit about what it is, which in hindsight was not too much. I told her that it is 50% benzodiazepine and had a half-life similar to klonopin, with some euphoria which I read in some trip reports. I also told her that it was a very potent drug which needed to be measured with a mg scale. As a former junkie she knew what I was talking about, the whole potency issue. At least we both thought we knew.

I was saying that I'm gonna test it first since I bought it and I collected the information about it. But … I FORGOT TO CALIBRATE AND PREPARE MY SCALE PROPERLY! That mistake almost took my life, so ALWAYS CALIBRATE your fucking scale before you test a substance! I'm serious you should do it or harm CAN and WILL happen to you.

I measured out 5 milligrams (AT LEAST THAT'S WHAT I THOUGHT) and intended to not take all the powder, putting away a pile of what I thought was 1 mg. I took the flubromazepam and washed it down with tea and a banana …. I remember saying something like "wow this feels great!," I had the info that it takes like 3 h or so to fully unfold. I remember telling her that before so she was like "Oh already?" That is everything I can recall. Honestly the next moment I was waking up at my family's a day later, who told me that I passed out. I have been trying to put the pieces together ever since. I messed around with pure benzodiazepine and I got fucked …. Now my friends and fam[ily] are terribly worried about me, which is beautiful, but it's also terrible when you keep in mind that it is because they thought they would lose me. I even went to the hospital of which I can't recall anything. Literally nothing: not going there, not going away from there or anything else in between. When I woke up I had a lot to explain to my friends and family plus I was still high. This experience … I see it as a second chance to live. I live. I did not kill a friend or a roomie or anybody else. I killed my reputation though and now people are concerned about me.

According to other trip reports, nothing points to flubromazepam but it all points to flubromazolam[14] since it [is] way superhypnotic. Man I should have done the allergy test. Also: the fucking package came without any label! Let that be a warning if you decide to try flubromazepam. Don't fucking eyeball. Always do the allergy test otherwise you are probably gonna die. Also don't measure with an uncalibrated scale but instead you should use volume dosing with propylene glycol solution at a low concentration …. (Anonymous report, posted in the harm reduction section of Forum Y, retrieved April 2015, modified by M.B. to safeguard participant anonymity)

User-based harm reduction faces the challenges of such easily available designer drugs that can be dangerous in very small dosages. Our participants repeatedly posted warnings about potential dangers to at least reduce harm within the community itself.[15]

A simple key word analysis of the trip reports section of the web forum returned the 50 most frequently used terms. Terms like *start, result, report, mg, test,* and *research* were frequently used, indicating a common theme: *research*. These words also reflect the ethics of collaboration and reporting that we found in the forum (cf. Doyle, 2011; Soussan & Kjellgren, 2014). The users encouraged each other to contribute to a collaborative body of knowledge and to openly discuss their findings in order to map the pharmacological and phenomenological territory of unknown substances.

In the interest of personal harm reduction, I have decided to come out of "lurking" status to ask this: Having received "tianeptine[16] sodium solution 100 mg/ ML" from a trusted, domestic vendor …. I tested it a couple times and found … it quite unpleasant, both in its flavor and effect. Not wanting to throw it away, I tried diluting it with regular grape juice to mask the flavor. Much to my surprise, the 0.5 ml caused a violent reaction. The entire shot of grape juice foamed up for a few seconds, then the tianeptine solution coagulated and rose to the top looking like tiny scrambled eggs (like in egg drop soup) before finally breaking up and sinking to the bottom. (Kaza at Forum Y, retrieved April 16, 2015, modified by M.B. to safeguard participant anonymity)

The web forums are important sources of information about new combinations of substances, their interactions, and their possible risks. The following excerpt shows how an upcoming experiment—combining a synthetic designer drug (allylescaline[17]) with *Kratom*[18]—can attract open discussion to reduce potential harms:

Blanka: I am getting ready to research allylescaline … and will write up a Trip Report afterwards but does anybody know if I can research [use] allylescaline while still having residual kratom under the microscope [being under the influence of]? I can't find anything on these two interacting and really don't want some chemical reaction from researching too close together. Also does anyone know of other substances interacting with allylescaline? And yes I have tried Google and [am] looking here for the answer.

Guile: Residual kratom from several hours before ally will be fine. Ally is agonist at one of same serotonin receptors that Kratom works as an antagonist, so it will dampen a particular reaction, but that's if you straight combo of those two. There is legitimate research into kratom antagonizing a specific receptor most phenethylamine psyches agonize. The reaction that kratom dampens with ally is ally's main show, so it's a waste to combo these two. Stomach discomfort is going to happen with ally regardless, unless you change the ROA [road of administration] to the orifice on the other end. (Forum Y, retrieved April 9, 2015, modified by M.B. to safeguard participant anonymity)

Given the unregulated, uncontrolled, and highly networked online environment around designer drugs, the above examples highlight the emergent nature of amateur expertise around these substances. Practices range from developing skills and methods to retrieving information available out there (chemical, biomedical, pharmacological, anecdotal, user generated, etc.) and maintaining dialogue, interest, and care in using these substances.

Conclusion

In this article, we have detailed how users of psychoactive drugs in the Netherlands and in online drug experimenting communities pursue *hassle-free* drug use in spheres attuned to spreading the good high. We have further suggested that these interrelated aims enact the practices of what could be called *harm reduction from below*.

The "general distrust of official guidance" is increasingly acknowledged in policy circles (Southwell, 2010) and one suggestion has been to replace the abstinence approach to drugs with "value-free education" (European Monitoring Centre for Drugs and Drug Addiction, 2010). We are skeptical of this approach. "Value-free education," we suggest, leaves little room for "peer involvement" in harm reduction discourse. Practices of drug use generate their own norms and values, and the sharing of information among drug-using peers is widely seen as an indispensable strategy to minimize potential risks and harms. While the challenges of implementing drug education programs in schools are manifold (cf. Cahill, 2007), considering the perspectives of drug users—their aims and desires, liminal as well as mundane experiences, and the practices through which they learn about drugs—will foster more meaningful dialogue than simple messages of promoting "healthy behavior." Think of Nina's desire to explore the limits of her sanity, Lenardo's comparison of the risks of drug use to those of mountaineering, and John's distrust of generalizing "expert" advice on what is dangerous. Engaging with such practices would imply acknowledging the reality of the socio cultural landscape within which young people make decisions about drug use and health.

In focusing on the values that animate drug-using communities, we have emphasized the central roles of *caring* and *sharing*. Our participants cared about their friends; their safety and well being; the quality of their leisure time spent together; and opportunities for adventure, learning, trying new

things, and transgressing boundaries. They cared about the quality, purity, and dosing of substances in the face of uncertainties. They cared about sharing their drugs, homes, and party spaces in ways that were most conducive to pleasant *hassle-free highs* and about sharing their knowledge, experiences, and warnings of bad trips for the benefit of their drug-using peers and a wider community of online experimenters.

We emphasize that most of our participants had regular sources of income, hobbies, friends who did not use drugs, and many other stakes in life and activities besides using drugs. Our aim here is not to generalize about all drug users but to point to the specificities of care that shape the "non problematic" drug use which emerges in the presence of users with a "multiplicity of meaningful roles" and stakes in life (cf. Decorte, 2001). In the final analysis, we argue that harm is not a direct, always present consequence of drug use, as the effects of drugs are shaped by user practices, which in turn are shaped by the everyday networks they emerge in. Harm reduction from above will be more effective when it engages with the collective, material, and affective harm reduction practices constantly evolving within drug-using communities.

Notes

1. See Riley and Blackman (2008) for drug use at home and Goulding and Shankar (2011) as well as Ruane (2014) for use at electronic dance music festivals.
2. ChemicalYouth is a project led by Anita Hardon, one of the guest editors of this special issue. The project is funded through a generous European Research Council (ERC) Advanced Grant (ERC-AdG-323646), 2013–2018.
3. The ascendancy of conservative politics means that "support for progressive drug policies is not as great as before" (Uitermark, 2004, p. 512) and "the bottom-up approach of the Dutch government is no longer pursued because international pressure helps law enforcement agencies as well as conservative political parties to restructure ecstasy policy in a top-down and law enforcement direction" (Uitermark, 2005, p. 65). An outcome of this is the zero-tolerance policy and sensationalist media accounts of isolated drug accidents.
4. Examples include http://www.unity.nl/, https://www.jellinek.nl/, http://www.mainline.nl/, http://www.drugs-test.nl/
5. We use the term "designer drugs" instead of the more common (legal) term "new psychoactive substances" (NPS). We believe the term NPS—defined as "substances of abuse, either in a pure form or a preparation, that are not controlled by the 1961 Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances, but which may pose a public health threat" (United Nations Office on Drugs and Crime, 2013, p. 1)—has a high risk of mis application. In our view, this is an ethnocentric *carte blanche* definition that also touches traditional medicines like Ayahuasca and Iboga that have not been defined as traditional

medicines in the last 15 or 30 years (European Commission, 2014). In contrast, the 1980s term "designer drug" (cf. Jenkins, 1999) emphasizes the design and laboratory manufacturing of synthetic chemicals that have little or no history of use (Dargan & Wood, 2013). Our participants also used the term "designer drugs" for synthetic NPS.

6. The focused ethnographic study of Inge van Schipstal (I.v.S.) was financed by the ERC-funded ChemicalYouth Project (ERC-AdG-323646) and followed the standard operating procedures approved by the ethics committee of the Faculty of Social and Behavorial Sciences of the University of Amsterdam (ethics approval December 4th, 2012). The data presented by S.M., H.M., and M.B. were collected during research conducted for their Medical Anthropology and Sociology (MAS) MSc thesis projects at the University of Amsterdam. Within MAS, all research is evaluated and reviewed in line with standard ethics operating procedures of the American Anthropological Association (http://ethics.americananthro.org/category/statement/) before researchers enter the field. These procedures include use of pseudonyms and other forms of anonymization, informed consent, and a more general ethical handling of field relations with research participants.

7. This is also underlined by the tendency of users to inform themselves via mostly user-driven websites (European Commission, 2014; Tackett-Gibson, 2007).

8. A gamma-aminobutyric acid (GABA) based neurotransmitter found in the human central nervous system (McKim & Hancock, 2013). Used inter alia as a medication to treat narcolepsy, gamma hydroxybutyrate (GHB) produces short-acting alcohol-like intoxication that makes it popular as a party drug and an aphrodisiac (Palamar & Halkitis, 2006). There is a fine line between effective dosage and overdose, which can result in a coma-like state (G-sleep). Given its potency, precise measurement is required (e.g., with a pipette). As dosages consumed while the previous dose remains active can easily result in overdose, there is also the need to measure time (for more on GHB, see Duff, 2005; Moore & Measham, 2012a; Nabben, 2010).

9. As pills in the Netherlands are almost always above 200 mg (up to 350 mg), harm reduction advice generally recommends beginning with a quarter of a pill (http://www.irisz.nl/drugs/xtc/tips-voor-als-je-xtc-gebruikt).

10. See also Moore and Measham (2008) for how ketamine users make their surroundings comfortable.

11. Poi is a flow toy often used at psychedelic trance festivals but also at the so-called "jams" in parks. There are two strings each with a relatively heavy ball attached to the end. The user of the poi swings the ropes in such a way that they form circles and patterns in the air. Sometimes the balls are set on fire to create a magical effect in the dark.

12. On how young drug users negotiate the contradictions between expert and situated knowledge through "calculated hedonism" or "controlled loss of control," see Measham (2004) and Green and Moore (2009).

13. An extremely potent benzodiazepine first synthesized in the 1960s (https://www.uniklinik-freiburg.de/filead min/mediapool/08_institute/rechtsmedizin/pdf/Poster2013/Moosmann_DesignerBenzodiazepine_ TIAFT2013.pdf).

14. A different NPS benzodiazepine that is extremely potent and hypnotic (Moosmann et al., 2015).

15. For considering, strengthening, and promoting "the preventive measures already taken by drug using ravers," see Van Havere, Tutenges, De Maeyer, Broekaert, and Vanderplasschen (2014).

16. A non-typical tricyclic antidepressant (Wagstaff, Ormrod, & Spencer, 2001).

17. A lesser known mescaline derivative (Shulgin & Shulgin, 1991).

18. A traditional medicine from Thailand sometimes used as an opioid substitute.

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