Assessing the Impact of Methamphetamine Use in Atlanta's MSM Community

DR. BRIAN J. DEW
GEORGIA STATE UNIVERSITY
Summer, 2007

Table of Contents

Acknowledgements

Many individuals and organizations helped to make completion of this needs assessment possible.

First, we thank the over 2,000 participants who completed questionnaires in person or via the Internet. These individuals took time from their daily routines to share their knowledge and perceptions of methamphetamine use among Atlanta's men who have sex with men (MSM) community.

We are very grateful to the participants of our six focus groups for sharing their thoughts and observations. These individuals, including HIV+ and HIV- recovering methamphetamine addicts, medical and other social service providers, African American MSM, and partners of methamphetamine users (abstinent and active), provided in-depth information that both reinforced our quantitative data and shed insight into additional community needs.

We are indebted to the 21 medical and legal professionals, substance abuse treatment representatives, mental and public health officials, and AIDS service providers who took several hours out of their busy schedules to share their first-hand accounts of the impact of methamphetamine use among local MSM.

An enthusiastic and diligent team of researchers was essential to the success of this endeavor. Research members included:

Steven Band
Michael Brubaker
Michael Dozier
Dee Desnoyers
Brian Dew
Andra Gailis
Tracey Gagnon
David Garner
Rich Jones
John Kim
Ron Herndon
Skanda Miraglia
Danielle Shareef
Kai Uslu

The following organizations kindly donated meeting space for this project:

AIDS Survival Project
Positive Impact

Finally, we gratefully recognize the Georgia Department of Human Resources for its identification of methamphetamine use among Atlanta's MSM community as an issue worthy of exploring and its willingness to devote financial resources towards a community-based needs assessment.

Executive Summary

Methamphetamine, also known as “tina,” “crystal,” “crystal meth,” “crank,” and “ice,” is the most powerful central nervous system stimulant available today. The drug is chemically related to amphetamine but, at comparable doses, the effects of methamphetamine are much more potent, longer lasting, and more harmful. Methamphetamine increases the release of very high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. When ingested, methamphetamine also causes the release of norepinephrine and serotonin. Routes of administration include oral ingestion, smoking, snorting, injecting, and anal insertion (referred to as booty bumping). Methamphetamine is a Schedule II stimulant due to its highly addictive properties and limited medical appeal.

Research has demonstrated the emerging influence of methamphetamine among men who have sex with men (MSM), frequently linking it to high risk HIV sexual behaviors such as having multiple sexual partners, decreased condom use, and reduced HIV seropositive disclosure. However, these findings have mostly been derived from samples of MSM residing on the West Coast or New York City. Consequently, little is known about the intersection of HIV and methamphetamine use among MSM in the Southeastern U.S. Given that Atlanta currently ranks third among all metropolitan cities in its proportion of MSM (behind only San Francisco and Seattle), it is particularly important to examine methamphetamine use in this city.

From January to August of 2006, a team of 10 masters and doctoral level researchers at Georgia State University, along with four recovering methamphetamine dependents who identified as MSM, conducted a needs assessment with regard to the use of methamphetamine use in Atlanta’s MSM community and its relationship with HIV/AIDS. Project staff collected over 2,000 questionnaires, conducted six 90-minute focus groups, and interviewed 21 key community professionals. Questionnaires were collected at various venues where MSM congregated (bars, gyms, local shopping malls, movie theater) as well as in online chat rooms. The focus groups were comprised of both HIV-positive and HIV-negative recovering methamphetamine users (length of abstinence ranged from two days to 13 years), partners of methamphetamine users, African American adult MSM, medical professionals and AIDS service providers. Face-to-face professional interviews were conducted with leading medical experts, substance abuse treatment providers, local clinicians specializing in working with members of the MSM community, religious leaders, and AIDS service providers. The purpose of the study was to provide guidance to public health and policymakers regarding the scope of the issue as well as to offer effective problem solutions based on community feedback.

Following are the key themes and findings that emerged from the various data collection methodologies:

***Community's Primary Drug Problem**:* Over 63% of questionnaire respondents identified methamphetamine as the most outstanding drug problem facing Atlanta's MSM community, followed by alcohol (19%) and ecstasy (9%). Among the online sample (N=507) obtained in MSM-oriented chat rooms, 62% reported lifetime methamphetamine use and 21% described methamphetamine use in the past week. Among questionnaire respondents, the following statistics were found:

- 76% knew a local MSM who had used methamphetamine,
- 44% acknowledged that greater than a quarter of their MSM friends had used methamphetamine,
- Three out of four respondents identified methamphetamine use as increasing among Atlanta's MSM,
- 87% believed that obtaining methamphetamine was somewhat or very easy to obtain for MSM.

Use in Multiple Venues: Methamphetamine use among MSM takes place in a variety of settings. When asked about locations in which respondents believed methamphetamine use to occur, the following venues were identified: dance clubs (74%), a friend's house (68%), one's home or apartment (66%), sex clubs (65%), and work (40%). Among chat room participants who reported lifetime use of methamphetamine (n=313), most participants consumed the drug at a friend's house (80%), followed by one's own house or apartment (73%), dance club (54%), hotel (49%), circuit party (40%), sex club (33%), and work (30%). Trafficking of methamphetamine in local sex clubs and dance settings occurs frequently.

Moderate Acceptability in MSM Community: In Atlanta's MSM community, there exists a general lack of stigma attached to the use of methamphetamine. While 62% of respondents described the drug's use as somewhat or very acceptable, results from the focus groups suggest that the drug remains the "glamorous drug of choice" by MSM of varying SES levels, professions, ages, and geographic regions. However, acceptability of methamphetamine use differed with regard to ethnicity as African American MSM reported greater stigma related to the drug's use than White or Hispanic MSM.

Impact on HIV/AIDS: Participants who reported increased familiarity with the drug (either greater number of friends who had tried methamphetamine or who acknowledged lifetime use of the drug) were most likely to report that methamphetamine use has significantly increased the number of Atlanta's new HIV infections. The greatest threat to HIV infection among methamphetamine users derived from the following:

- Inconsistent use of condoms,
- High prevalence of sexual activity with anonymous partners,
- Participation in "three-way" or group sex,
- Sharing of used needles to inject the drug,
- Failure to disclosure one's HIV-positive status.

Of the 131 HIV-positive participants who completed an online survey, 27% (n = 31) reported that methamphetamine use was directly involved in seroconverting. Fluctuations in viral load and T-cell counts caused by inconsistent medication adherence due to methamphetamine use were noted by medical professionals and AIDS service providers.

Role of the Internet: Participants identified the utilization of Internet-based escort services, chat rooms, and downloadable pornography as important features of their methamphetamine use. Online male escorts who target Atlanta's MSM community were recognized as both sex partners and potential drug dealers. Chat rooms were cited as the preferred route of "P & P," (party and play). Over 78% of the online sample of methamphetamine users reported using Internet chat rooms to locate other MSM with which to use methamphetamine and engage in sexual activity. Other potential ways of meeting sexual partners included bars (42%), sex clubs (33%), and circuit parties (24%). Among dependent users of the drug, greater amounts of fear, paranoia, and generalized anxiety became common, thereby curtailing the sexual pursuits of others. Instead, methamphetamine dependents who described their use "near the bottom" reported using the Internet to download pornography for the purposes of sexual pleasure.

Desire for Community Intervention: Compared to cities such as San Francisco, Los Angeles, and Seattle, methamphetamine use in Atlanta's MSM community is considered a recent phenomenon. Yet, there exists a significant level of local concern with regard to its prevalence. In our sample, over 92% of respondents declared that they were somewhat or extremely troubled by the impact of methamphetamine in Atlanta's MSM community. Nearly 97% stated that it was somewhat or very important for Atlanta's MSM community to address this particular issue.

Need for Inclusive Social Marketing Campaign: An integrated, diverse, non-judgmental approach to prevention is needed. Internalized homophobia, such as feelings of low self-worth, inadequacy, depression, and being regarded as "sinful," was consistently mentioned as an obstacle to emotional well-being. For many MSM, methamphetamine is used to alleviate internalized homophobia as well as minimize fear of aging, and reduce loneliness. Using methamphetamine as a coping resource following a positive HIV test was also cited by participants who received a positive diagnosis within the past two to three years. A social marketing campaign must, therefore, be non-judgmental in its approach and scope.

Results from the focus groups and professional interviews stressed the importance of initially targeting non users and recreational users via a variety of outreach efforts, including in-person and online. These efforts include developing educational materials that are specific to targeted populations such as youth, men of color, and HIV-positive persons. These materials would be distributed to local bars/dance clubs, sex clubs, bath houses, restaurants, and bookstores. Outreach efforts that involve in-person visitation and distribution of materials are especially needed in Atlanta's various sex clubs and bath houses. Efforts to establish collaboration with the management of these facilities for educational/prevention purposes are especially noted. Inclusion of prevention messages in

various online chat rooms were also consistently mentioned in focus groups and professional interviews. The use of banner ads with anti-methamphetamine slogans and having prevention workers provide education to chat room visitors were two of the most frequently cited needs. Similar to local owners of sex clubs and bath houses, relationships between prevention professionals and owners of MSM-oriented websites need to be cultivated.

Introduction

Methamphetamine is a central nervous system stimulant that is structurally similar to but more potent than amphetamines. Methamphetamine, colloquially known as "tina," "crank," "speed," "crystal," "crystal meth," and "ice," are classified under the phenylethylamine class of stimulant drugs and are related to both amphetamine and MDMA (Ecstasy). Pharmacologically, methamphetamine is a schedule II drug under federal regulations due to the severe likelihood of dependence and high potential for abuse. The drug can be injected, inhaled, smoked, ingested, or inserted into one's rectum (reference to booty bump).

Multiple epidemiological surveillance systems point to methamphetamine use as one of the fastest growing drug problems in the United States. Drug treatment, arrest, emergency room, and mortality data all indicate an increasing use of methamphetamine, especially in the Southeastern U.S. (Community Epidemiological Work Group [CEWG], 2006; Drug Enforcement Administration [DEA], 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2005). The drug's usage was largely confined to the western United States during the 1990's. In the last five years, however, use of methamphetamine has spread nationwide and is now recognized as the fastest growing substance abuse problem on the East Coast, including the state of Georgia.

Short-term effects of methamphetamine use include increases in heart rate, blood pressure, temperature, vasoconstriction, rate of breathing, and cardiac arrhythmia. Long-term use of methamphetamine is related to stroke, decreases in lung functioning, pulmonary hypertension, poorer cognitive functioning, and decreased mental health (Greenwell & Brecht, 2003). Long-term use of methamphetamines is also related to decreased mental health, especially with regard to increased anxiety and depression (Greenwell & Brecht, 2003).

Significant public health concerns are also associated with at-risk sexual behavior among its users, particularly among MSM. Certain psychological and behavioral effects of methamphetamine use, such as hypersexuality, euphoria, a lowering of sexual inhibitions, increased confidence and self-esteem are caused even when consumed in small amounts (Halkitis, Parsons, & Stirratt, 2001). The impact of this drug on MSM sexual expression has resulted in increases in unsafe sexual activity. This escalation in unprotected sex has been documented by a number of studies linking methamphetamine use and HIV infection among MSM (Farabee, Prendergast, & Cartier, 2002; Frosch, Shoptaw, Huber, Rawson, & Ling, 1996; Gorman, 2003; Halkitis & Parsons, 2002). Research has demonstrated the emerging influence of methamphetamine in the MSM community (Molitor, Traux, Ruix, & Sun, 1998; Newmeyer, 2003; Prestage et al., 2001), frequently linking it to high risk HIV sexual behaviors such as having multiple sexual partners (Halkitis, Parsons, & Wilton, 2003), decreased condom use (Fernandez et al., 2004), and an increased probability of HIV infection and having another STD (Gorman, Nelson, Applegate, & Scrol, 2004; Shoptaw, Peck, & Reback, 2003). Other research has found a decrease in

HIV seropositive disclosure (Larkins, Reback, Shoptaw, & & Veniegas, 2005) and a reduction in HIV medication adherence (Reback, Larkins, & Shoptaw, 2003) among methamphetamine-using MSM. Multiple social contexts where MSM meet others and use methamphetamine, such as circuit parties (Kurtz, 2005; Lee, Galanter, Dermatis, & McDowell, 2003; Mattison, Ross, Wolfson, & Franklin, 2001), bath houses (Binson, Woods, Pollack, Paul, Stall, & Catania, 2002), sex clubs (Halkitis, Parsons, & Stirratt, 2001), and internet chat-rooms (Benotsch, Kalichman, & Cage, 2002; Dew & Chaney, 2005) have been identified.

Although research has documented the link between HIV at-risk behavior and methamphetamine use among MSM, the majority of these studies have occurred on the West Coast and in New York City. With the exception of two research studies based in Miami (Fernandez et al., 2005, Kurtz, 2005) there exists no evidence of public health concerns related to methamphetamine use among MSM in the Southeast, including Atlanta, Georgia.

Atlanta is recognized as the methamphetamine distribution capital of the Eastern United States due to its extensive highway, rail, and air transportation systems. Atlanta leads all other metropolitan cities east of the Mississippi River in methamphetamine-related treatment admissions, drug seizures, and emergency room reports. Furthermore, Atlanta currently has the third highest proportion of gay men in the country, behind only San Francisco and Seattle. Combine Atlanta's large supply of methamphetamine with its large MSM population, it is essential that empirical efforts be accomplished in order to determine potential public health threats.

The purpose of this project was to conduct a needs assessment regarding the current state of methamphetamine use in Atlanta's MSM community and to determine its relationship to HIV/AIDS. In addition, it was the goal of the researcher to determine effective components of an inclusive, diverse, and innovative social marketing campaign that could target this community of potential methamphetamine users.

The following four questions were addressed in this project:

1. What is the current state of methamphetamine use in Atlanta's MSM community?
2. How has methamphetamine use impacted new HIV infection rates among Atlanta's MSM?
3. For HIV-positive MSM what are the sexual, medical, and mental health implications associated with methamphetamine use?
4. What are the components of an effective social marketing campaign targeting methamphetamine using MSM?

It is my hope that findings from this research project promote a better understanding of methamphetamine use among Atlanta's MSM and contribute to the formation of an effective educational campaign related to this issue.

Brian J. Dew, Ph.D.
Principal Investigator

Sampling Methodology

The project's data collection and analysis had four major components: interviews with key informants, paper questionnaires, online surveys, and focus groups.

In preparing for the scope of this project, researchers conducted 60-90 minute interviews with eight expert professionals who had direct knowledge of the impact of methamphetamine use among Atlanta's MSM, including the effect of HIV/AIDS. These interviews included medical doctors, substance abuse treatment clinical directors, AIDS service providers, and recovering methamphetamine addicts who identified as MSM. These experts helped to identify venues for data collection, to pilot test the questionnaire and online survey, and to obtain suggestions for focus group questions and participants. An additional 13 interviews were conducted throughout the data collection process in order to corroborate research findings from the in-person questionnaires, the online survey, and the focus groups. All 21 interviews were audiotaped, transcribed, and coded for determining themes. Interviews were completed by a team of graduate-level research assistants with expertise in the study of addictions and/or public health concerns associated with MSM. Coding and development of themes was completed by Dr. Brian Dew, the project's primary investigator.

Given feedback from the expert interviews, it was determined that obtaining data from local bar and dance club patrons was a priority. Consequently, a two-page questionnaire was developed that could be completed in such a setting. Owners and/or managers from over 10 local bars and dance clubs that catered to a MSM clientele were contacted via telephone and offered an explanation of the research project. Permission was sought for a team of four researchers to come to the bar or dance club, set up a table in which information about methamphetamine was available, and provide data collection materials. From these discussions, only a limited number of bar owners/managers would provide access to their patrons if the questionnaire asked about individual drug use or HIV status. Consequently, a questionnaire was developed that asked about the following: a) demographic information (age, gender, sexual orientation, and county currently residing); b) perceptions and knowledge of methamphetamine use in Atlanta's MSM community; and c) knowledge of the impact of methamphetamine use on HIV/AIDS.

The use of the Internet as a means for MSM to identify potential sexual partners with whom to use methamphetamine was consistently noted in interviews with expert informants. As a result, it was determined that establishing online strategies for data collection was integral to the project's success. Consequently, relationships with management teams from American Online (AOL) and the website, www.manhunt.net, were established. The use of these sites also allowed for greater inquiry into personal drug use, sexual behaviors when using methamphetamine, and current HIV status. Online data collection from AOL required a researcher to enter an Atlanta MSM-oriented chat room. A researcher had the following member ID, METHRESEARCHGSU, with a profile documenting the research purpose, criteria for participation, and survey link. No coercion

of chat room visitors was conducted. Interested persons could read the researcher's profile and go directly to the 15-20 minute survey. A banner ad was placed on the Georgia homepage of the www.manhunt.net site. Interested visitors could click on the banner ad and go directly to the online survey.

In the spring and summer of 2006, six focus groups were convened at Atlanta's Positive Impact, a local non-profit AIDS service provider located between Midtown and downtown Atlanta. These groups consisted of the following members: a) recovering methamphetamine MSM addicts (HIV status not differentiated); b) previous methamphetamine using MSM who identified as HIV-positive (2 groups); c) partners of MSM who either previously or actively use methamphetamine; d) African American MSM; and e) medical, treatment, and AIDS service providers who provided direct service to methamphetamine using MSM. These populations were selected to ensure a diverse understanding of the impact of methamphetamine on Atlanta's MSM community, as well as solicit comments to forming an effective social marketing campaign. Focus groups were held from 7:00 p.m. to 8:30 p.m. Each focus group was comprised of between 7 and 9 participants representing a broad range of experiences and backgrounds. Focus groups were moderated by Dr. Brian Dew, principal investigator and Mr. Michael Brubaker, project coordinator. All focus groups were audiotaped, transcribed, and coded for purposes of research analysis.

Findings

Methamphetamine Use Among Atlanta's MSM

The findings from interviews and focus groups determined that the use of methamphetamine in Atlanta's MSM community is not a new phenomenon. Participants reported that "speed," "crank," and "meth," had circulated among local MSM for the past 20-25 years. The white or yellow powder drug form, while locally produced in "mom and pop" laboratories often located in basements, trailers, and hotel rooms, contained purity levels ranging from 30% to 40%. However, methamphetamine's appeal in the 1970's and 1980's was not considered widespread. Among Atlanta's MSM, the drug was viewed as "lower class" compared to cocaine.

In the late 1990's, it was reported that a newer, more potent form of the drug was introduced to local MSM. Instead of a powder substance, this form of methamphetamine was a clear, colorless, crystalline solid. Soon to be called "ice," "tina", or "crystal," its purity levels were found to be between 80% and 90%, nearly 2-3 times the purity levels of the former type. Starting in 1998, participants reported increased community interest and acceptance among Atlanta's MSM. During this time, greater amounts of crystal methamphetamine were distributed in bars and dance clubs as an alternative to both cocaine and ecstasy.

Based on reports from law enforcement officials, medical providers, substance abuse treatment clinicians, and recently abstinent users, methamphetamine use in Atlanta's MSM use has risen every year since the late 1990's. Although no general prevalence studies exist with MSM in Atlanta, participants estimated that between 10% to 20% of local MSM have used methamphetamine in the last year.

Results from this study support the previous claim that methamphetamine use is widespread and increasing among Atlanta's MSM. Nearly three out of four participants of the in-person questionnaires and online surveys reported that they knew a MSM friend who had used methamphetamine. Over 44% of all respondents disclosed that over a quarter of their MSM friendship networks had used the drug in the past year. In this study's online sample of 507 MSM participants, 62% of respondents reported lifetime use of the drug. When asked when their last use of the drug occurred, over 21% reported consuming methamphetamine in the last week.

The majority of face-to-face interviews were conducted with White respondents (80%), followed by African American (8%), Latino (5%), and Asian/Pacific Islanders (3%). A greater percentage of online respondents were White (86%) while African Americans and Latinos represented 4% respectively.

Due to the sensitive nature of illicit drug use, researchers were forbidden to inquire about individual drug use at bars, dance clubs, and other MSM-frequented venues. Consequently,

no data exist with regard to frequency of methamphetamine use outside this online sample. However, it is clear that the majority of the local MSM community is aware of methamphetamine's dangerous impact. When asked to select the most outstanding drug problem facing Atlanta's MSM community, over 63% of participants identified methamphetamine, followed by alcohol (19%) and ecstasy (9%). Participants viewed methamphetamine use as dangerous and increasing. Over 76% of respondents reported that methamphetamine use was somewhat or significantly escalating among Atlanta's MSM.

Participants reported that one of the primary reasons for the increased rates of methamphetamine use among MSM is the availability and ease of obtaining the drug. Participants from multiple focus groups focused on locations in which methamphetamine could easily be purchased. If one was a recreational user of the drug, it was reported that the most common location for purchasing methamphetamine was via a friend or from a dealer at a local dance club or bar. For more frequent users of methamphetamine, other methods of obtaining the drug were mentioned. Frequent (including dependent users) users were more likely to obtain their drugs from dealers located in Internet chat rooms and sex clubs or from distributors who marketed themselves as male escorts.

With regard to Internet chat rooms focus group participants pointed out that distributors of methamphetamine establish a list of previous and potential buyers in the form of a buddy list. A methamphetamine dealer utilizes their buddy list to instant message these potential online buyers. Distribution of methamphetamine also occurs in Atlanta's MSM-oriented bath houses. A dealer will rent a room for 12 to 48 hours at a time, bring his laptop computer with wireless internet connection, and communicate with persons inside and outside of the sex club. Methamphetamine sales are made inside the sex club (typically in the dealer's room) or outside in the parking lot. Participants also disclosed that greater numbers of Atlanta's male escorts are selling methamphetamine as an added service to their customers. Male escorts typically advertise via the Internet, MSM-oriented local publications, or depend on "word of mouth" referrals.

Methamphetamine is a drug that appeals to a wide variety of Atlanta's MSM. Results from the online survey, focus groups, and interviews with professional experts indicate that the drug is being used by diverse groups of MSM, including those individuals with varying income levels, ages, and professions. In our online sample, there was no statistical difference between income level and use of methamphetamine. Hence, one was as likely to use the drug if he earned greater than $100,000 a year as if he made $20,000 during the same period.

Results from multiple data sources found that methamphetamine use in Atlanta's MSM community is not limited to a certain age group. However, individuals between the ages of 18 and 28 years of age, as well as persons between 35 and 45 years old were found to be at highest risk of methamphetamine use. Persons of varied professional backgrounds are also consuming the drug, thereby highlighting the broad appeal of methamphetamine in Atlanta's MSM community.

Findings from this study indicate that African American MSM prefer the use of methamphetamine at lower rates than Whites or Hispanic MSM. Various interviews with key professionals and results from our online surveys indicated this racial differentiation. Because African Americans comprise over 60% of Atlanta's population, the primary researcher determined it was necessary to explore the use of this drug with a sample of African American MSM. As a result, a focus group comprised of nine African American MSM was held. While only a third of the focus group participants had used methamphetamine, individuals were able to share the perceptions of this drug's use within the African American MSM community. Reasons for lower rates of methamphetamine use among African American MSM included the following: a) traditional drug distribution patterns within the African American community have not included methamphetamine; b) the perception that methamphetamine is a "white person's" drug; and c) belief that using methamphetamine will cause one to lose control for extended periods of time. For African American MSM, this latter issue was especially relevant as it related to their relationship with law enforcement. Among the three African American MSM who acknowledged methamphetamine use, all reported initially using the drug with a White MSM. The consensus among these focus group participants was that methamphetamine was slowly entering their community and that increasing number of African American drug dealers were offering methamphetamine in addition to or in place of crack and powder cocaine.

Questionnaire respondents and focus group participants stressed that the local use of methamphetamine among MSM occurs in multiple venues. In this study, locations in which methamphetamine use by MSM was perceived to have occurred was investigated as well as actual places in which one has used methamphetamine was assessed. Most respondents believed that methamphetamine use occurred in dance clubs and bars (74%), followed by a friend's home or apartment (68%), one's home or apartment (66%), sex clubs (65%), bath house (59%) and work (40%). For those online respondents that reported lifetime use of methamphetamine, using at a friend's house was most often cited (80%), followed by using at one's home (73%), dance club (54%), hotels (49%), circuit parties (40%), sex clubs (33%) and work (30%). When asked about the location in which one preferred to use methamphetamine, nearly half of the online sample of methamphetamine users reported one's own home, while over a quarter preferred a friend's house or apartment. While 4% reported preferring to use at a circuit party, less than 2% of participants favored using in a sex club or bath house.

The routes of administration among local MSM include swallowing, snorting, smoking, injecting, and inserting the drug rectally (also known as booty bumping). Among the 313 online participants who identified as having used methamphetamine at least once, the following questions were asked: a) which ways have you put methamphetamine into your body?, and b) what is your preferred way of using methamphetamine? Respondents acknowledged diverse methods of administration, while identifying snorting (74%) and smoking (72%) as the most common routes of use, followed by booty bumping (31%), swallowing (24%), and injection (14%). When asked to disclose one's preferred route of

administration, most methamphetamine users reported smoking (41%) and snorting (38%), followed by injecting (8%), booty bumping (7%), and swallowing (4%).

Results from the focus groups and interviews with key informants conclude that there has been a gradual move away from snorting the drug due to increased levels of purity associated with the "ice" form of the drug. Participants pointed out that although many MSM preferred snorting, extended periods of nasal insertion of the drug resulted in significant damage to the nasal cavity's mucous membranes. Consequently, participants believed that further increases in smoking methamphetamine were expected. According to multiple medical and drug treatment sources, the proportion of MSM who prefer to inject methamphetamine has remained stable at approximately 10% to 15% of users.

To understand the drug's popularity within Atlanta's MSM community, it is essential to address particular side effects of methamphetamine. Informants from multiple data sources highlighted the following reasons for the drug's local appeal: a) decreased levels of internalized homophobia; b) heightened sexual performance; c) diminished social anxiety, including shyness and fear of rejection; d) reduced loneliness; and e) enhanced association with a social network. Participants cited being raised and/or living in the South as a primary reason for hearing negative messages about what it means to be a MSM. Words such as "an abomination," "disgusting," "worthless," and "embarrassment" were most frequently cited by focus group members and among key informants. The internalization of these messages caused significant threats to the MSM's sexual identity development and his emotional wellbeing.

Internalized homophobia, already identified as the primary cause for depression and feelings of low self-worth, also had direct consequences in the MSM's sexual life. The majority of former methamphetamine users identified that for the first time, while under the influence of methamphetamine, he was able to engage in sexual activity with a male partner and not be inundated with negative shameful messages. In fact, this effect of methamphetamine use was so powerful that several participants acknowledged that "sex will never be the same again without meth[amphetamine]." Participants also identified the sexual benefits of using methamphetamine. Due to the drug's stimulant effects, MSM acknowledged engaging in longer lasting sexual activity, having heightened energy that allowed for "rougher" sex, and experiencing a delayed but ultimately more pleasurable orgasm.

For the majority of former methamphetamine-using focus group participants, using the drug produced an elevated confidence in one's self. Whether in person or on the Internet, methamphetamine allowed its user to approach strangers without fear of a negative response, particularly those MSM perceived to be potential sexual partners. Among recreational users of methamphetamine, participants were less likely to isolate socially when using the drug. Instead, users preferred to go to a dance club, bar, sex club, or bath house—all locations in which additional methamphetamine could be purchased. For MSM in their late 30's and 40's, the use of methamphetamine was a means to remain socially

integrated with a younger crowd, while minimizing fears about being physically unattractive due to aging.

Participants acknowledged that these perceived benefits occurred within a MSM community that attaches relatively low stigma to alcohol and illicit drug use, including methamphetamine. Nearly 62% of in-person questionnaire and online survey participants reported that methamphetamine use was either somewhat or very acceptable within Atlanta's MSM community. These results were supported by key community informants as well as by former methamphetamine using MSM and their partners. The use of illicit drugs, especially those substances that heighten sexual pleasure such as nitrate inhalants, ecstasy, and methamphetamine, were perceived to be a normative component for many MSM social networks.

Impact on new HIV Infection Rates

Nearly two-thirds of participants who completed either an in-person questionnaire or an online survey believed that local use of methamphetamine had caused an increase in new HIV seroconversions among Atlanta's MSM community. These perceptions were substantiated by multiple expert informants who had direct knowledge of new HIV infections caused by this drug. Results from interviews with medical doctors and nurses, AIDS service providers, public health officials, and substance abuse treatment clinicians indicated that between 20% and 35% of current new HIV infections among Atlanta's MSM were linked to methamphetamine use. Among white MSM who have tested positive for HIV in the past two years, the use of methamphetamine was considered a factor in over half of these new infections. For new HIV infection rates among white MSM over the age of 35, methamphetamine use was involved with over 65% of cases. Research results indicated a low prevalence of HIV infection among African American and Latino MSM due to methamphetamine use (less than 2%). New HIV infections were not found limited to a particular socio-economic class or income level. Of the 507 participants in the study's online sample, nearly 26% (n = 131) self identified as HIV-positive. Of the HIV-positive online participants, 27% (n = 35) acknowledged seroconverting because of methamphetamine use.

The reasons for the link between methamphetamine use and HIV infection among Atlanta's MSM can be categorized into sexual at-risk behaviors and sharing of needles associated with injecting the drug. Furthermore, research results indicated that an HIV-positive diagnosis likely produces a "spiraling out of control behavior" which includes increasing amounts of methamphetamine use, unsafe sexual behavior, and failure to disclose ones HIV-positive status with sexual partners. In the following section, results from multiple data sources among Atlanta's MSM community as they relate to HIV seroconversion are presented.

Sexual At-Risk Behaviors. For Atlanta's MSM, using methamphetamine increased the likelihood of engaging in multiple sexual at risk behaviors. A greater number of sexual partners were mentioned by former MSM users of the drug as well as those professionals offering direct medical and clinical services to this population. These participants suggested that the average number of monthly sexual partners for methamphetamine using MSM ranged from 7 to 180. Sexual partners were most likely found in Internet venues such manhunt.net, bigmuscle.com, AOL.com and gay.com or at bars, dance clubs, sex clubs, and bath houses. Sexual activity could be limited to one partner or involve multiple persons (referred to as group sex).

Focus group participants acknowledged that local MSM-oriented group sex events involving methamphetamine occurred almost daily in such settings as one's home, hotel room or suite, or sex club. Participants stated that invitations to these events were distributed via Internet chat rooms, telephone contact, or word of mouth. The number of participants varied from 5 to 20. The length of these events, which was often dependent on the available supply of methamphetamine, lasted from four to six hours to three to four days. Focus group participants indicated that these group sex events place an individual at particular risk due to the lack of available condoms and inherent peer pressure to not to use protection. Participants reported that many of these sexual partners, whether one-on-one or in a group context, were anonymous, thereby reducing the likelihood of seropositive disclosure.

Participants stressed that methamphetamine had significant consequences on sexual performance. Methamphetamine often restricted the user's ability from obtaining a full erection, a necessity to engage in insertive anal intercourse. Thus, participants acknowledged that the user was likely to assume a receptive sexual position or use erectile dysfunction medication in order to engage in insertive anal intercourse. When choosing to use methamphetamine and engage in a receptive sexual position, 31% of our online sample of users had inserted the drug into their rectum prior to intercourse. By placing non-dissolved shards of methamphetamine into one's rectum, followed by receptive anal intercourse, the user significantly increases the probability of HIV infection.

Due to the stimulant nature of methamphetamine the MSM user also experiences heightened energy, as well as delayed ejaculation, thereby increasing the likelihood of damage (tearing) to the rectal membranes when the user was engaging in receptive anal intercourse. Participants stressed that if an insertive partner was using a condom, the likelihood of breakage significantly increased due to "rougher sex" while under the influence of methamphetamine.

Participants acknowledged that many sexual at-risk behaviors were attributed to impaired decision making, a consequence of methamphetamine use. Several focus group participants relied on their own experiences when stating that their ability to protect themselves was "overpowered by the drug." Results indicated that the drug and its link to sexuality were so strong that many local MSM could not rely on safe-sex messages of using protection.

Focus group participants admitted that when they were under the influence of methamphetamine, they were unable to think about friends who had died of AIDS, fears associated with HIV testing, or consequences of previous at-risk sexual activity. As noted by several medical professionals, these specific recollections have historically been cited as reasons for protection against HIV.

Sharing of Needles. Reports from community experts and focus group participants found that injecting methamphetamine was the preferred route of administration for approximately 10% to 15% of Atlanta's MSM community. In determining the percentage of new HIV infections that can be attributed to injecting methamphetamine, medical and AIDS service providers maintained that it is difficult given the multiple co-occurring sexual risk behaviors. For example, "slamming" methamphetamine is often accompanied by unprotected anal and oral intercourse. However, focus group participants acknowledged several incidents which led either to their own seroconversion or the infection of others through injecting methamphetamine.

Out of 16 HIV-positive focus group participants, three acknowledged serconverting as a result of injecting the drug. HIV infection of these participants demonstrated similar behavioral patterns. All three participants disclosed that they had previously used methamphetamine prior to logging onto an online site. Once online, they communicated with potential sexual partners that wanted to use methamphetamine together and arranged to visit the person's apartment or home. Methamphetamine was used within the first 15 minutes after arrival. After this initial snorting or smoking the drug, the potential sexual partner mentioned that he preferred to shoot the drug and agreed to share "his works" only after injecting himself. For all three participants, it was their first time injecting a drug of any kind. Two HIV-positive focus group members acknowledged sharing "dirty" needles with sexual partners. On all accounts, methamphetamine use had previously occurred prior to injecting. Not one participant recalled a discussion regarding HIV status prior to injecting the other person.

Participants acknowledged that compared to smoking or snorting the drug, there existed greater stigma attached to injecting methamphetamine within Atlanta's MSM community. Consequently, professionals within the medical and substance abuse treatment fields agreed that the actual rate of injecting may be underreported. Public health officials also noted that the purity levels of methamphetamine range from 80% to 90%. At these levels, a user is able to obtain a significant high from either snorting or smoking the drug. However, if purity levels decrease, public health officials reported concerns that greater numbers of Atlanta's MSM will transition to injecting in order to obtain a similar high.

***Impact of HIV-Positive Notification on Methamphetamine Use*.** Focus group participants pointed out that for many local methamphetamine-using MSM, the decision to obtain an HIV test most often occurred because a medical provider (doctor or nurse), substance abuse treatment official (some facilities require HIV testing upon admission), a close friend or partner suggested testing, or an MSM perceived that he was at risk for infection.

HIV testing typically took place in a medical office, treatment center, or AIDS Service organization that provides free testing. Fewer number of participants reported going to the public health department, citing uncertainty regarding how a MSM would be treated and unfamiliarity with the location of these offices.

Participants cited that the behavioral and emotional impact of a positive HIV test was frequently dependent on the setting in which the person was notified. If the MSM was notified of his test results while engaged in substance abuse treatment, he was more likely to receive the counseling services needed to cope with the diagnosis, receive direct medical attention and necessary referrals, and remain in substance abuse treatment. He also was less likely to use methamphetamine as a coping mechanism than individuals who were notified of their seroconversion in other settings.

For the majority of focus group participants who identified as HIV-positive, receiving a positive diagnosis outside of substance abuse treatment centers led to a "downward spiral" behavioral pattern. This reaction to one's seroconversion was also corroborated by medical and public health officials. Many focus group participants, upon receiving a HIV diagnosis, engaged in prolonged binge use of methamphetamine, including increased amounts and frequency of drug use. For individuals who were employed, this period was particularly challenging as absenteeism increased and work productivity diminished. Many participants reported losing their jobs as a consequence of this binge period, thereby potentially losing medical benefits associated with previous employment.

Focus group participants also reported increased sexual at-risk activity following a positive HIV test, including unprotected insertive and receptive anal sex with multiple anonymous partners. As one focus group member shared, "I couldn't decide if I wanted to live or not, and I certainly didn't care if this trick did as well." The use of methamphetamine allowed for a temporary escape from the realities of a HIV-positive diagnosis. Depression and anxiety, resulting from both the drug's withdrawal and seroconversion notification, were debilitating for many newly diagnosed MSM. However, due to one's drug use, these MSM were unlikely to be engaged in medical and other community (AIDS service providers, mental health delivery networks) systems that could address both their medical and psychosocial needs.

Implications for the HIV-positive MSM

MSM who were HIV positive and using methamphetamine reported a range of effects on one's sexuality, physical health, and emotional wellbeing. In the following section, results from interviews with key community leaders, focus groups, and questionnaire and survey responses are provided.

Impact on Sexual Activity. Results from the online sample indicated that among 507 participants, 26% (n = 131) identified as HIV-positive. Among the HIV-positive

participants, there was a high prevalence of methamphetamine use, including both lifetime (79%; n = 103), past year (65%; n = 85), and past month (57%; n = 75). An analysis of the sexual behaviors of the HIV-positive users of methamphetamine revealed significant at-risk activities. Among the 85 HIV-positive participants who reported using methamphetamine in the past year, over half (n = 44) acknowledged engaging in unprotected receptive anal intercourse during the previous 12 months. Nearly all (43 of 44) of these participants reported that methamphetamine use was involved during at least one episode of unprotected receptive anal intercourse. When examining the prevalence of unprotected insertive anal intercourse, 34% (n = 29) of past year users of methamphetamine who identified as HIV-positive reported engaging in this at-risk sexual activity. Furthermore, 9 out of 10 respondents who had engaged in unprotected insertive anal intercourse admitted that methamphetamine use had been involved on at least occasion. When asked when this particular sexual behavior last occurred, 20% identified during the past 24 hours, 19% in the last week, 31% in the previous month, and 30% during the past year.

For HIV-positive users of methamphetamine, locations for finding male sexual partners were most often the Internet, followed by sex clubs, bath house, public cruising, and bars/dance clubs. Participants reported mixed levels of self-disclosing their seropostive status when methamphetamine use was involved. For sexual partners obtained via the Internet, nearly a quarter of participants shared their HIV status in an online profile. Of the participants who did not include one's serostatus in an online profile, only 12% consistently shared this information prior to sexual activity, 16% acknowledged approximately half the time, and the remaining 47% of respondents failed to disclose it. In venues such as sex clubs and bath house, or via public cruising, disclosure of one's HIV-positive status when methamphetamine was involved resulted in even less serostatus disclosure. In these sexually charged locations, 8% reported sharing this information with every partner, 9% acknowledged it half the time, and most participants did not disclose.

Results obtained from focus groups comprised of HIV-positive former methamphetamine-using MSM provided insight into the influence of methamphetamine on sexual activity. First, the stimulant effects associated with methamphetamine use often provided the HIV-positive user increased energy, thereby counteracting potential fatigue associated with some HIV medications. In particular, the use of methamphetamine allowed for the HIV-positive MSM to engage in longer sexual activity without tiring. Second, HIV-positive MSM users of methamphetamine experienced less rejection with regard to locating sexual partners particularly because of lowered expectations for seropositive self-disclosure. The use of the Internet and the local availability of sex clubs and bath houses were often cited as venues that sharing one's HIV-positive status was "not expected nor the norm." Finally, the relationship between methamphetamine use and sexual activity increased the prevalence of sexual addiction in this population. For some focus group participants, once they stopped using methamphetamine, it became necessary to address their compulsive sexual behaviors as a means of working a personal recovery plan.

Medical Implications. Results from interviews with various medical professionals were consistent with the responses from recovering HIV-positive methamphetamine users who participated in the focus groups. The consumption of methamphetamine had severe medical consequences for the HIV-positive user. The treatment of HIV requires consistent medical attention, including potential pharmacology modification and regular blood testing. HIV-positive users of methamphetamine were likely to neglect medical appointments. Medical professionals, including doctors and nurses, both commented that their methamphetamine using MSM clients would disappear for months at a time without notice. Once returning, the user's viral loads often had increased and t-cell counts diminished significantly.

Methamphetamine use resulted in lower medication adherence. Focus group participants acknowledged that use of their HIV medications often became secondary to locating and using methamphetamine. Consequently, medications were used inconsistently or not at all. This impaired ability to adhere to consistent HIV medication regimens has led to the development of medication-resistant viral strains among Atlanta's HIV-positive MSM.

Participants cited the need to take certain HIV medications with food or at a certain time of day. When under the influence of methamphetamine participants acknowledged that appetite suppression and distortion of time was particularly problematic. Sleep deprivation while under the influence of methamphetamine was also common. Poor dietary habits and sleep deprivation combined to make the methamphetamine user particularly vulnerable to medical illness. Participants also cited fears that taking their HIV medications would cause the methamphetamine user a diminished high.

For heavier users of methamphetamine in Atlanta's MSM community the loss of employment was cited often as a consequence of one's drug use. The loss of income was a considerable challenge but for many HIV-positive individuals the loss of health insurance was especially difficult. A loss of insurance often meant transitioning, even if temporary, from a medical provider to a non-profit AIDS service organization for HIV-related care. Participants acknowledged difficulty in maintaining consistent medical attention during this transition time.

Mental Health Challenges. For social workers, psychologists, counselors, and other clinicians working with HIV-positive methamphetamine-using MSM, an array of challenges were acknowledged. These findings were also mentioned by focus group members as impediments to achieving optimal mental health. Citing intense cravings as well as the prolonged withdrawal period associated with methamphetamine, these professionals shared that their clients experienced more difficulty remaining abstinent from methamphetamine than any other drugs to which clients were addicted.

Extended periods of anxiety and paranoia were cited as impediments to their clients following up with appointments. High rates of depression were also noted, thereby leading

to an elevated risk of suicide. Low sense of self-worth, internalized homophobia, unresolved guilt, and shame around one's HIV serostatus were also reported as common.

An additional mental health challenge that addresses the cognitive and behavioral link between sex and methamphetamine use was noted. Helping a client to understand what it means to be both HIV-positive and sexual, without the use of mood altering substances, was critical to minimizing potential triggers for relapse. Assertiveness training and role-plays around self-disclosure of one's HIV-positive status were also found to be beneficial.

Lack of insurance and the cost of obtaining mental health services were noted as hindrances to receiving appropriate care. Focus group participants who were HIV-positive were not aware of cheaper options for psychological services offered at various non-profit organizations. Consistently, focus group members acknowledged that it would be advantageous for these organizations to advertise their clinical services within the local MSM community more effectively. Furthermore, discerning the names of local mental health clinicians with expertise in both HIV-oriented issues and methamphetamine use was also difficult for many focus group members.

Ingredients of an Effective Social Marketing Campaign

In all focus groups and interviews with key professionals, questions were asked regarding the current state of community education and prevention related to methamphetamine use among Atlanta's MSM community. The responses to this question were nearly identical and could be summarized as "poor," "non-existant," "too little, too late," and "slower than other metropolitan cities." A sense of urgency to address this issue was stressed by the majority of both focus group and interviewed participants. In particular, a coordinated and collaborative effort between local MSM community leaders, public health officials, AIDS service organizations, and city government was most often mentioned as the optimal solution to addressing this most prevalent substance abuse problem among Atlanta's MSM community. An initial result of this collaborative effort would be the production of an innovative social marketing campaign that would heighten the attention of Atlanta's MSM community to the deleterious effects of methamphetamine, including the impact of HIV/AIDS. When asked what components should be included in this social marketing campaign, participants offered a variety of suggestions. In this section, considerations for the development of a successful social marketing campaign are explored.

First, this social marketing campaign must be diverse and tailored to meet the needs of various age groups, as well as differing ethnicities and income levels. The findings from this needs assessment concluded that methamphetamine use was prevalent among users of various ages, especially among young adults (18-25 year olds) and adults (35-45 year olds). While the majority of Atlanta's MSM users of methamphetamine are white, it was also important to recognize that a greater number of African American and Latino MSM were using the drug. Furthermore, focus group participants particularly stressed that the development of any future social marketing campaign must address MSM of various

income levels and/or professional identities. In addition to demographics, results with key medical and public health professionals stressed that this social marketing campaign should incorporate outreach efforts to different forms of users, including local MSM injectors of the drug. Participants preferred not to have a uniform, broad, and "one size fits all" approach to these education and prevention efforts.

Second, focus group and interview participants suggested that an effective social marketing campaign targeting MSM users of methamphetamine must include content that addresses the sexual implications of the drug. The majority of focus group participants acknowledged that they were first introduced to the drug in sexually charged situations. Many of these participants reported not knowing the sexual risks of methamphetamine use prior to initial use. Participants suggested that a forthright discussion of the impact of methamphetamine use on MSM sexuality and its public health implications be an integral part of the social marketing campaign.

Focus group participants overwhelmingly believed that a social marketing campaign should target an array of service providers. Medical doctors and nurses were most often pointed out for needing education. Focus group participants and key informants stressed that local medical providers often were unaware of the impact of methamphetamine among local MSM and therefore, unlikely to screen effectively for its use. Participants pointed out that their medical professional would most likely respond to the anxiety and depression caused by methamphetamine rather than address the core issue of drug use. Many participants also identified AIDS service providers as a critical target of a social marketing campaign. Although participants mentioned that members of these organizations provide important services to the community, they also agreed that many of their clinical providers were not informed of the health risks associated with methamphetamine nor were they knowledgeable of the drug's unique side effects and extended withdrawal period.

While nearly all participants agreed that substance abuse treatment is a valid resource for MSM users of methamphetamine, some participants viewed local treatment centers as not providing a safe and supportive environment for MSM. Fears of homophobia among the treatment staff and other patients/clients were especially noted. An unwillingness to address the sexual implications of the drug in individual and group settings was also noted as particular concerns. The development of a social marketing campaign targeting substance abuse treatment providers should involve both sensitivity training and a greater understanding of the drug's appeal within Atlanta's MSM community.

Most key informants and focus group participants agreed that an effective social marketing campaign should include outreach to law enforcement officials. Although focus group participants did not reach a consensus about the exact role of local police in curbing methamphetamine use, greater collaboration with the Fulton and DeKalb County Police Department was encouraged. Some participants wanted the police to have a more active role in enforcing drug policy within MSM-oriented bars, dance clubs, and sex clubs. Greater surveillance of the MSM oriented chat rooms was also mentioned by key

informants and limited number of focus group members. However, other participants raised concerns regarding the increased presence (including undercover officers) of police in these venues, citing a history of police discrimination against local MSM.

When asked which community members needed to be part of an integrated social marketing campaign, the majority of participants included the owners and managers of Atlanta's MSM-oriented bars and nightclubs. Participants believed that these individuals were extremely important in accessing current and potential users of methamphetamine for educational and outreach efforts. Participants noted that gaining their support would potentially allow for a team of health educators and outreach workers to distribute methamphetamine-related literature to their bar or dance club's clientele. Furthermore, participants were nearly unanimous that bar and dance club owners and managers could do more to enforce anti-drug policies. In addition to bars and dance clubs, participants of both the focus groups and key informant interviews suggested that any city-wide social marketing campaign must contain management's support at Atlanta's MSM-oriented sex clubs and bath houses.

Many participants volunteered suggestions regarding how to increase community consciousness regarding methamphetamine use. First, the majority of participants believed it was critical to participate in various MSM-related events held throughout the year. For example, several participants cited the presence of the Atlanta Crystal Meth Task Force's efforts at the 2006 Pride Festival and Parade (carrying coffins in the parade and wearing t-shirts that include "meth = death" messages) as extremely helpful in increasing awareness. Participants cited that the delivery of the anti-methamphetamine message coming from individuals within Atlanta's MSM community was especially constructive. Participants noted other local events such as Black Pride, Broken Hearts Summer Party, MSM-oriented sporting events, and regional Circuit parties as potential locations to provide methamphetamine related educational materials. Participants also stated that targeted advertising campaigns located in select print media (David Magazine, Southern Voice) were a viable means to reach potential methamphetamine users.

Several participants cited the need to conduct community forums in order to raise awareness about the destructive effects of methamphetamine. Similar to HIV-related events held in the 1980's and early 1990's, participants suggested that the purpose of this event should be to invite local MSM to hear local medical and public health leaders, and community members explain how this drug is impacting Atlanta's MSM community. Participants shared that this event should be free to the public and forbidden to the press, thereby allowing for greater candidness in sharing of information.

Focus group participants and key informants overwhelmingly reported that the development of a social marketing campaign must include an online component. Given the Internet's role as the preferred method of meeting anonymous sexual partners among MSM, participants stated the following steps need to be taken to address this issue: a) establish relationships with the management of several online websites that are popular

with Atlanta's methamphetamine using MSM, including manhunt.net, bigmuscle.com, and gay.com; b) determine effective approaches to conducting education and outreach methods to an online population; c) put together an outreach team that would enter MSM-oriented chat rooms and provide education and materials via links to other websites; and d) evaluate the effectiveness through a combination of qualitative and quantitative data collection strategies.

The existence of greater acceptability of drug use with Atlanta's MSM community was perceived as a challenge in the effort to persuade MSM not to use methamphetamine. Some participants believed that the rise of methamphetamine use provided the opportunity to address this macro-level issue in a public forum. However, other participants were hesitant to single out drug use among MSM for fear that it would further stigmatize this community.

The remaining feature of a successful social marketing campaign involved the need for a compassionate and nonjudgmental approach to its delivery. Participants acknowledged that for many MSM who suffer from certain psychosocial pressures such as low self-esteem, isolation, and fear associated with aging, methamphetamine use can be particularly inviting. For HIV-positive men, methamphetamine can also be used a means of emotional escape.

Recommendations

Results from this research project indicated that there exists a strong desire within Atlanta's MSM community for public health officials to provide an immediate and diverse social marketing campaign geared toward prevention of methamphetamine use. In this section, specific recommendations as pointed out by focus group participants and community informants are included.

A coordinated, multi-faceted social marketing campaign targeting diverse populations within the local MSM community needs to be developed, implemented, and evaluated. Such a campaign would contain the following elements:

1) **Include members of the local MSM community to educate others regarding the effects of methamphetamine use**. Results determined that MSM are more likely to listen to methamphetamine prevention messages if they are delivered from local MSM. Because of the strong connection between sexual activity and methamphetamine use, participants acknowledged that it would be more comfortable to engage in such a conversation with other MSM. Issues of shame surrounding sexual behavior, HIV status, and sexual orientation were also noted as reasons for inclusion of MSM in the delivery of prevention messages. Furthermore, participants also stressed the importance of having local MSM with histories of methamphetamine addiction be included in educational formats.

2) **Develop relationships with the management of Atlanta's bath houses and sex clubs in order to provide outreach prevention efforts to potential at-risk MSM.** Efforts to collaborate with and collect data in Atlanta's bath houses and sex clubs were unsuccessful. Repeated telephone voice messages to owners and managers were not returned nor was there a response to a mailed inquiry. Results from this study indicate that these venues are preferred places in which MSM use methamphetamine and engage in at-risk sexual behavior, including sex with anonymous partners, group sex, low rates of condom use, and diminished seropositive self-disclosure. Atlanta's bath houses were also identified as a preferred location for buying/selling of methamphetamine. Focus group participants pointed out that methamphetamine distribution at bath houses was commonplace and "no drug policies" were not enforced by management.

3) **Target prevention messages for online websites that cater to local MSM (aol.com, manhunt.net, gay.com, man4man.com, bigmuscle.com)**. Results from this study suggest that the Internet has become the preferred means for Atlanta's MSM to meet potential sexual partners. However, participants acknowledged a lack of safe sex messages in these

venues. While the majority of focus group participants had sought after methamphetamine using MSM via Internet chat rooms, few individuals reported ever seeing methamphetamine prevention messages. Specific recommendations for online prevention messages included banner advertisement in chat rooms, embedded links to web pages that contain methamphetamine information specific to a MSM population, harm reduction approaches to methamphetamine use, and having prevention specialists participate in online chats for purposes of educating others. Such efforts would need to be followed by an evaluation process in order to determine the effectiveness of specific online campaign components.

4) **Develop prevention materials that target diverse MSM community**. Participants identified methamphetamine use to be problematic among MSM of various ages, income levels, and races/ethnicities. Therefore, developing one methamphetamine prevention message and applying it to Atlanta's macro MSM community was not recommended by a large majority of study participants. Furthermore, study results also found that efforts to provide education and prevention messages needed to target various types of populations based on previous use of methamphetamine. These prevention campaigns would target: a) non-users of methamphetamine; b) recreational users; and c) abusing and addicted users.

5) **Change community perspectives with regard to glamorization and acceptability of methamphetamine use.** Multiple data sources indicated that the use of methamphetamine was considered both alluring and attractive by many local MSM. Its use is considered largely acceptable among the community at-large while its side effects are perceived as low to moderate risk by many MSM, especially among recreational users of the drug. Lower levels of stigma surrounding drug use among Atlanta's MSM were also noted as an obstacle to changing community perspectives.

6) **Provide training to substance abuse treatment workers, public health officials, medical providers, and AIDS service employees regarding the unique risks of methamphetamine within Atlanta's MSM community.** Research findings determined that methamphetamine using MSM were fearful to utilize existing service providers. The majority of focus group participants perceived that local substance abuse treatment facilities were not embracing of MSM nor were they safe places for MSM to receive treatment. Uncertainty regarding available treatment options and managed care restrictions on inpatient services were also problematic.

HIV testing for methamphetamine using MSM was noted as being especially stressful. Focus group participants pointed out that they were fearful at the reaction of health officials and unsure of the legal consequences if they reported illicit drug use. However, participants perceived public health systems to be less homophobic than local substance abuse treatment facilities.

Participants acknowledged that they often lied to medical providers in order to cover up their methamphetamine use or the topic of drug use was simply not discussed. Individuals

who had medical providers with large numbers of MSM clients were most likely to ask about methamphetamine use. MSM patients who had not disclosed their sexuality to a medical provider were least likely to be asked about methamphetamine use. Greater screening for methamphetamine use, knowledge of appropriate referrals for substance abuse treatment and AIDS service providers, and comfortableness with same-sex sexuality were identified as important qualities of an effective medical provider.

Because of the relationship between HIV and methamphetamine use, AIDS service providers were identified as critical "front line" caregivers. Participants perceived AIDS service organizations to be mostly safe venues for MSM while identifying less fear of judgment associated with acknowledging illicit drug use. However, participants stressed the importance of their caseworker to be knowledgeable of referral sources, including recovery support, medical attention, and counseling options.

7. **Collaborate prevention efforts with public health officials and drug researchers from other metropolitan areas**. National epidemiological trends of methamphetamine use among MSM illustrate that widespread use of the drug in Atlanta is a new phenomena. In contrast to west coast cities such as San Diego, Los Angeles, San Francisco, and Seattle, Atlanta's MSM use of methamphetamine became increasingly popular in the last 8 to 10 years. Consequently, these cities have already developed unique social marketing campaigns geared towards MSM users of the drug. Efforts will need to be made to establish and maintain relationships with public health officials and drug researchers in these metropolitan areas in order to discern effective marketing strategies and tips for evaluating successful programming.

Methodological Limitations

Results from this research study provide greater insight into the impact of methamphetamine use in Atlanta's MSM community. However, these findings should be cautiously interpreted in lieu of several methodological limitations. First, data collection strategies involving face-to-face interviews and online questionnaires were based on convenient sampling rather than random sampling. Yet, in-person completion of questionnaires was conducted in venues where higher proportions of MSM congregate. To obtain a diverse group of participants, efforts were made to conduct face-to-face data collection in a variety of settings such as a movie theater that was showing a mainstream gay-related film (Brokeback Mountain), MSM-oriented gymnasiums, bars, dance clubs, social functions, and outdoor shopping venues.

Our research efforts were limited in that the majority of social and community venues would not allow the collection of information related to one's drug use or HIV status. Therefore, it must be noted that the quantitative data related to HIV prevalence and individual sexual at-risk behaviors presented in this report is limited to only the sample of 507 Internet users. Through analysis of focus group transcriptions other high-risk locations were identified, especially local bath houses and sex clubs. Future research into the impact of methamphetamine use among Atlanta's MSM needs to include data collection efforts at these particular venues.

A second potential limitation involved the collection of unverifiable data. Information derived from completion of questionnaires or participation in focus groups were collected via uncorroborated self-reports, which may have been influenced by social desirability. Therefore, the accuracy with which respondents reported experiences as related to methamphetamine use, including sexual risk behaviors, other drug use, and access to resources can not be confirmed. Given that gay and bisexual men belong to a community that experiences stigmatization and discrimination, it is possible that their answers could be skewed toward portraying themselves in more of a positive way. In order to minimize this "halo effect," the survey administrators were instructed to encourage participants to be as honest in their answers as possible.

A third methodological limitation is related to the completion of the online survey instrument. Online surveys were limited to those MSM who used aol.com and manhunt.net. However, it is possible that MSM who use these two particular online sites are not representative of MSM who use other MSM-oriented Internet sites. Previous research results by the primary investigator indicate that, whereas aol.com is not a highly

preferred site for active methamphetamine users, www.manhunt.net ranks in the top two as preferred sites for users to visit.

A fourth potential limitation concerns the failure to conduct a focus group with active methamphetamine users. On three different occasions a day and time was established with at least six active methamphetamine users (defined as having used in the past week). For two of three focus groups, no participants attended the scheduled event. On one attempt, one interested active methamphetamine user attended. Obtaining data from active users would have been especially helpful in discerning HIV-related risks as well as to corroborate data from focus groups with former users.

Because the data could not be obtained from a population-based, random sample, the findings provide a descriptive, exploratory understanding of the impact of methamphetamine use on Atlanta's MSM community. These findings may or may not reflect the larger methamphetamine-using MSM community in Atlanta, GA. Furthermore, these findings may not be generalizable to MSM populations in other metropolitan areas. The introduction of methamphetamine into Atlanta, especially the Mexican-produced ice form, is a fairly recent phenomenon compared to metropolitan cities on the West Coast and in Texas. As a result, perceptions based on community surveys may not reflect as much knowledge about this substance as compared to residents of other metropolitan areas.

Although potential limitations do exist, this needs assessment represents the most comprehensive examination of methamphetamine use in Atlanta's MSM community ever conducted. While it is apparent that the use of methamphetamine is the primary drug problem among Atlanta's MSM community, it is also clear that methamphetamine has had a significant impact on local HIV infection rates. An innovative and diverse social marketing campaign is needed to address this growing pubic health concern.

References

Benotsch, E., Kalichman, S., & Cage, M. (2002). Men who have met sex partners via the Internet: Prevalence, predictors, and implications for HIV prevention. *Archives of Sexual Behavior, 31*(2), 177-183.

Binson, D., Woods, W., Pollack, L., Paul, J., Stall, R., & Catania, J. (2001). Differential HIV risk in bathhouses and public cruising areas. *American Journal of Public Health, 91*(9), 1482-1486.

Community Epidemiological Work Group (2005). Metropolitan Atlanta drug use trends. *Proceedings of the Community Epidemiology Work Group*. Bethesda (MD): National Institutes of Health.

Dew, B., & Chaney, M. (2005). The relationship among sexual compulsivity, internalized homophobia, and HIV at-risk sexual behavior in gay and bisexual male users of internet chat rooms. *Journal of Sexual Addiction and Compulsivity, 12*, 259-275.

Drug Enforcement Administration, Office of Diversion Control (2005). *Year 2004 Annual Report: National Forensic Laboratory Information System (NFLIS).* Washington, DC.

Farabee, D., Prendergast, M., & Cartier, J. (2002). Methamphetamine use and HIV risk among substance-abusing offenders in California. Journal of Psychoactive Drugs, 34(3), 295-300.

Fernandez, J., Varga, L., Perrino, T., Collazo, J., Subiaul, F., Rehbein, A., et al., (2004). The internet as recruitment tool for HIV studies: Viable strategy for reaching at-risk Hispanic MSM in Miami? *AIDS Care, 16*(8), 953-963.

Frosch, D., Shoptaw, S., Huber, A., Rawson, R. & Ling, W. (1996). Sexual HIV risk among gay and bisexual male methamphetamine abusers. *Journal of Substance Abuse Treatment*, 13(6), 483-486.

Gorman, M., (2003). Research with gay drugs users and the interface with HIV: Current methodological issues for social work research. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy, & Research*. 15(1-2), 79-94.

Gorman, E., Nelson, K., Applegate, T., & Scrol, A. (2004). Club drug and poly-substance abuse and HIV among gay/bisexual men: Lessons gleaned from a community study. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 16*(2), 1-17.

Greenwell, L., & Brecht, M. L. (2003). Self-reported status among treated methamphetamine users. *The American Journal of Drug and Alcohol Abuse*. *29*(1), 75-104.

Halkitis, P., & Parsons, J. (2002). Recreational drug use and HIV-risk sexual behavior among men frequenting gay social venues. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy, & Research.* 14(4), 19-38.

Halkitis, P., Parsons, J., & Stirratt, M. (2001). A double epidemic: Crystal methamphetamine drug use in relation to HIV transmission among gay men. *Journal of Homosexuality, 41*(2), 17-35.

Halkitis, P., Parsons, J., & Wilton, L. (2003). Barebacking among gay and bisexual men in New York City: Explanations for the emergence of intentional unsafe behavior. *Archives of Sexual Behavior, 32*(4), 351-357.

Kurtz, S. (2005). Post-circuit blues: Motivations and consequences of crystal meth use among gay men in Miami. *AIDS and Behavior, 9*(1), 63-72.

Larkins, S., Reback, C., Shoptaw, S., & Veniegas, R. (2005). Methamphetamine-dependent gay men's disclosure of their HIV status to sexual partners. *AIDS Care, 17*(4), 521-532.

Lee, S., Galanter, M., Dermatis, H., & McDowell, D. (2003). Circuit parties and patterns of drug use in a subset of gay men. *Journal of Addictive Diseases, 22*(4), 47-60.

Mattison, A., Ross, M., Wolfson, T., & Franklin, D. (2001). Circuit party attendance, club drug use, and unsafe sex in gay men. *Journal of Substance Abuse, 13*(1-2), 119-126.

Molitor, F., Traux, S., Ruiz, J., & Sun, R. (1998). Association of methamphetamine use during sex with risky sexual behaviors and HIV infection among non-injection drug users. *Western Journal of Medicine, 168*, 93-97.

Newmeyer, J. (2003). Patterns and trends of drug use in the San Francisco bay area. *Journal of Psychoactive Drugs, 35*, 127-132.

Prestage, G., Van De Ven, P., Grulich, A., Kipax, S., McInnes, D., & Hendry, O. (2001). Gay men's casual sex encounters: discussing HIV and using condoms. *AIDS Care, 13*(3), 277-284.

Reback, C., Larkins, S., & Shoptaw, S. (2003). Methamphetamine abuse as a barrier to HIV medication adherence among gay and bisexual men. *AIDS Care, 15*(6), 775-785.

Shoptaw, S., Peck, J., & Reback, C. (2003). Psychiatric and substance dependence comorbidities, sexually transmitted diseases, and risk behaviors among methamphetamine-dependent gay and bisexual men seeking outpatient drug abuse treatment. *Journal of Psychoactive Drugs, 35*, 161-168.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2005). *2005 state estimates of substance use.* DHHS Publication No. (SMA) 283-98-9008. Rockville, MD.

Appendix A
The Intersection of Methamphetamine Use and HIV: Investigating the Impact among Atlanta's MSM

Face-to-Face Needs Assessment Questionnaire

DIRECTIONS: Thank you for completing this survey. The following questions specifically relate to crystal meth use among gay and bisexual men in Atlanta.

1. What is your current age? _____ years old

2. Gender: ____Male ____Female _____MTF Transgendered
   _____FTM Transgendered

3. What county (e.g., Fulton, DeKalb, Cobb) do you live?
   _____

4. How would you describe your racial background?
   a. ___ American Indian or Alaskan Native
   b. ___ Black
   c. ___ White
   d. ___ Asian or Pacific Islander
   e. ___ Hispanic
   f. ___ Other, Specify _____

5. Which of the following comes closest to describing your sexual orientation?
   a. ____ Gay or Lesbian
   b. ____ Bisexual
   c. ____ Heterosexual
   e. ____ Uncertain

6. Currently, what are the three biggest drug problem in Atlanta's gay/bisexual male community? (please rank 1 for largest problem, 2 for second most problem, and 3 for third most significant problem)
   a. ____ Alcohol
   b. ____ Cocaine (powder)
   c. ____ Cocaine (crack)
   d. ____ Ecstasy
   e. ____ GHB
   f. ____ Crystal Meth
   g. ____ Xanax/Valium
   h. ____ Other _____

7. Do you know a gay/bisexual male in Atlanta who has used crystal meth?
   a. ____ Yes
   b. ____ No

8. What percentage of your gay/bisexual friends in metro Atlanta has used crystal meth?
   a. ____ None of my gay/bisexual friends has used methamphetamine
   b. ____ 1-10%
   c. ____ 11-25%
   d. ____ 26-50%
   e. ____ 51-75%
   f. ____ > 75%

9. In Atlanta, is crystal meth being used by gay/bisexual men in the following places? (please circle your answers)

a. Home	(**Yes**	**No**	**Don't Know**)
b. Work/School	(**Yes**	**No**	**Don't Know**)
c. Friend's House	(**Yes**	**No**	**Don't Know**)
d. Dance clubs	(**Yes**	**No**	**Don't Know**)
e. Sex Clubs	(**Yes**	**No**	**Don't Know**)
f. Bath Houses	(**Yes**	**No**	**Don't Know**)
g. Erotic Video Store	(**Yes**	**No**	**Don't Know**)

10. What is your perception of crystal meth use in Atlanta's gay/bisexual male community?

1	2	3	4
Decreasing Significantly	Decreasing Somewhat	Increasing Somewhat	Increasing Significantly

11. How difficult is it for gay/bisexual men to obtain crystal meth in Atlanta?

1	2	3	4
Very Difficult	Somewhat Difficult	Somewhat Easy	Very Easy

12. How important is it that Atlanta's gay/bisexual male community address crystal meth use?
   a. ____ Extremely important
   b. ____ Very important
   c. ____ Somewhat important
   d. ____ Not at all important

13. How has methamphetamine use impacted HIV infection among gay/bisexual men in Atlanta?
    a. ____ Decreased HIV infection
    b. ____ Increased HIV infection
    c. ____ Had no effect on HIV infection
    d. ____ Don't know

14. If gay/bisexual men are using methamphetamine and having sex, how likely are they to use condoms?

    1----------2----------3----------4
    Very Likely Likely Somewhat Likely Not at all Likely

15. Do you agree with the following statement: "If a gay man uses crystal meth, he is likely to engage in sex?"
    a. ____ Don't agree
    b. ____ Somewhat disagree
    c. ____ Somewhat agree
    d. ____ Agree
    e. ____ Don't know

16. Have you ever communicated with a gay/bisexual guy online (e.g., chat-room) who you knew was a crystal meth user?
    a. ____ Yes
    b. ____ No

17. In your opinion, how acceptable does Atlanta's gay community consider crystal meth use?

    1----------2----------3----------4
    Very Unacceptable Somewhat Unacceptable Somewhat Acceptable Very Acceptable

18. How concerned are you with methamphetamine use in Atlanta's gay/bisexual male community?
    a. ____ Extremely concerned
    b. ____ Very concerned
    c. ____ Somewhat concerned
    d. ____ Not at all concerned

Appendix B

The Intersection of Methamphetamine Use and HIV: Investigating the Impact among Atlanta's MSM

Online Needs Assessment Questionnaire

1. What is your age? _____

2. What is your gender?
____ Male
____ Female
____ MTF Transgender
____ FTM Transgender
____ Intersex

3. What best describes your current sexual orientation?
____ Gay
____ Lesbian
____ Bisexual
____ Heterosexual
____ Asexual
____ Uncertain

4. In which county (e.g., Fulton, DeKalb) are you currently living? _____

5. In what geographical area are you currently living?
____ Urban
____ Suburban
____ Rural

6. What is your ethnicity?
____ American Indian/Alaskan Native
____ Black
____ White
____ Asian
____ Hispanic
____ Biracial
____ Multiracial
____ Other
(Please specify _____)

7. What is the highest level of education that you have obtained?

____ Elementary School
____ 5th-8th Grade
____ Some High School
____ High School Graduate
____ GED
____ Technical Training
____ Some College
____ College Degree
____ Some Graduate School
____ Graduate School Degree
____ Other
(Please specify _____)

8. What best describes your current work status?

____ Work Full Time (More than 35 hours per week)
____ Work Part Time (Less than 35 hours per week)
____ Unemployed and Looking for Work
____ Unemployed and Not Looking for Work
____ In School/Training
____ On Welfare
____ Social Security Income/Disability Income
____ Other (Please specify _____)

9. What was your past year's income from legal activities/sources?

____ Have No Source of Income
____ $1-$5,000
____ $5,001-$9,999
____ $10,000-$19,999
____ $20,000-$29,999
____ $30,000-$39,999
____ $40,000-$49,999
____ $50,000-$59,999
____ $60,000-$69,999
____ $70,000-$79,999
____ $80,000-$89,999
____ $90,000-$99,999
____ Greater than $100,000

10. What do you consider to be the single biggest drug problem in Atlanta's gay/bisexual male community?

____ Alcohol	____ Power Cocaine	____ Crack Cocaine
____ Ecstasy	____ GHB	____ Crystal Meth
____ Xanax/Valium	____ Marijuana	____ Non-prescribed Opiates

11. What would you consider to be the 2nd biggest drug problem in Atlanta's gay/bisexual male community?

____ Alcohol	____ Power Cocaine	____ Crack Cocaine
____ Ecstasy	____ GHB	____ Crystal Meth
____ Xanax/Valium	____ Marijuana	____ Non-prescribed Opiates

12. What would you consider to be the 3rd biggest drug problem in Atlanta's gay/bisexual male community?

____ Alcohol	____ Power Cocaine	____ Crack Cocaine
____ Ecstasy	____ GHB	____ Crystal Meth
____ Xanax/Valium	____ Marijuana	____ Non-prescribed Opiates

13. Do you personally know a gay/bisexual male in Atlanta that has used methamphetamine in the past year?

____ Yes
____ No

14. What percentage of your gay/bisexual male friends have used methamphetamine?

____ None
____ 1%-10%
____ 11%-25%
____ 26%-50%
____ 51%-75%
____ Greater than 75%

15. What level of concern do you have related to methamphetamine use in Atlanta's gay community?

____ Extremely Concerned
____ Very Concerned
____ Somewhat Concerned
____ Not At All Concerned

16. Based on your knowledge, what locations are methamphetamine being used in Atlanta's gay/bisexual male community? (Please check all that apply)

____ Home	____ Work	____ Dance Club
____ Sex Club	____ Erotic Video Store	____ Circuit Parties
____ Hotels	____ Other (Please specify _____)	

17. What is your perception of methamphetamine use in Atlanta's gay/bisexual male community?

____ Decreasing Significantly
____ Decreasing Somewhat
____ Same
____ Increasing Somewhat
____ Increasing Significantly

18. Which of the following best describes your ability to acquire methamphetamine?

____ Very Difficult
____ Somewhat Difficult
____ Somewhat Easy
____ Very Easy
____ Don't Know

19. What has been the impact of methamphetamine on HIV infection rates among Atlanta's gay/bisexual male community?

____ Decrease HIV
____ Increase HIV
____ No Effect
____ Don't Know

20. How important is it for local gay men to be educated regarding the consequences of methamphetamine use?

____ Extremely Important
____ Very Important
____ Somewhat Important
____ Not At All Important

21. How acceptable is it in Atlanta's gay/bisexual male community for individuals to use methamphetamine?

____ Very Unacceptable
____ Somewhat Unacceptable
____ Somewhat Acceptable
____ Very Acceptable

The following questions are related to your drug use:

Which best describes your last use of the following drugs (one selection per drug):

	Past 24 hours	Past week	Past month	Past year	Have used but longer than a year ago	Never have used
Alcohol						
Marijuana						
Powder Cocaine						
Crack Cocaine						
Ecstasy						
GHB						
Ketamine						
Methamphetamine						
Non-prescribed Opiates						

22. If you have used methamphetamine, in which ways do you administer the drug? (check all that apply)

____ Oral ____ Smoke ____ Snort
____ Inject ____ Booty Bump ____ Hotrail
____ Other
(Please specify _____)

23. If you have used methamphetamine in the past, what is your preferred method of taking the drug?

____ Oral ____ Smoke ____ Snort
____ Inject ____ Booty Bump ____ Hotrail
____ Other
(Please specify _____)

24. If you have used methamphetamine in the past, have you ever used the drug in the following locations? (Please check all that apply)

____ Home ____ Work ____ Dance Club
____ Sex Club ____ Erotic Video Store ____ Circuit Parties
____ Hotels ____ Other (Please specify _____)

25. If you have used methamphetamine in the past, where is your preferred location for using the drug?

____ Home ____ Work ____ Dance Club
____ Sex Club ____ Erotic Video Store ____ Circuit Parties
____ Hotels ____ Other (Please specify _____)

26. When you have been under the influence of methamphetamine, have you ever engaged in the following face-to-face sexual activities? (check all that apply)

	Past 24 hours	Past week	Past month	Past year	Have used but longer than a year ago	Never have used
Masturbation						
Unprotected oral sex (giver)						
Protected vaginal sex						
Unprotected vaginal sex						
Receptive protected anal						
Receptive unprotected anal						
Insertive protected anal						
Insertive unprotected anal						

27. While under the influence of methamphetamine, have you used the following locations to meet other gay/bisexual males in Atlanta for sexual purposes? (please check)

____ Internet ____ Bar/Club ____ Sex Club
____ Bath House ____ Circuit Party ____ Friend's House
____ Other
(Please specify _____)

28. If gay/bisexual men in Atlanta are using methamphetamine, how likely is it that they are using condoms?

____ Very Likely
____ Likely
____ Somewhat Likely
____ Not at all Likely

29. Gay/bisexual men in Atlanta who are using methamphetamine are likely to engage in sexual activity.

____ Don't Agree
____ Somewhat Disagree
____ Somewhat Agree
____ Agree
____ Don't Know

30. Have you ever engaged in online communications (i.e. chat rooms, instant messaging) with another gay/bisexual male from Atlanta who acknowledged using methamphetamine?

____ Yes
____ No

31. What is your current HIV status?

____ HIV Positive
____ HIV Negative
____ Don't Know
____ Never Been Tested

32. Do you believe that methamphetamine contributed to your seroconversion?

____ Yes
____ No
____ Not HIV Positive
____ Other

Appendix C

The Intersection of Methamphetamine Use and HIV: Investigating the Impact among Atlanta's MSM

Key Informant Interview Questionnaire

Impact of HIV/AIDS on community

•When did you first recognize the impact of methamphetamine use in the MSM community of Metropolitan Atlanta?

•What demographics were more representative of that population of users? (Explore ethnicity, age, socioeconomic status, education, disability status, veteran status.)

•Who came to you for services? (Meth users? Partners? Family members? Employers? Etc.)

•What problems were occurring?

•How did this impact change over time?

•What trends are you seeing today?

•How has methamphetamine use impacted the prevalence of HIV/AIDS among the MSM community in Metropolitan Atlanta?

•How has this changed over time?

•How has methamphetamine usage impacted your ability to serve the HIV+ MSM community?

•In your opinion, what future trends should Metropolitan Atlanta expect in regards to methamphetamine usage and HIV seroconversion among gay men?

Risk Factors

•In the Metropolitan Atlanta MSM community, who are the persons at highest risk to try methamphetamine?

- Demographics (Explore ethnicity, age, socioeconomic status, education, disability status, veteran status)
- Place of residence (inner city, suburbs, Mid Town, other)
- Occupations
- Behaviors (Explore sexual, internet, social activities, work activities, etc.)

- Attitudes

•In the Metropolitan Atlanta MSM community, what persons are more likely to contract HIV while using methamphetamine?

- Demographics (Explore ethnicity, age, socioeconomic status, education, disability status, veteran status)
- Place of residence (inner city, suburbs, Mid Town, other)
- Occupations
- Behaviors (Explore sexual, internet, social activities, work activities, etc.)
- Attitudes

•What co-occurring issues do methamphetamine users typically have? (HIV, Hep A,B,C, specific mental illnesses, other health issues)

•How does methamphetamine use impact at-risk behaviors among gay men who are already HIV+?

•Are HIV+ methamphetamine users more or less likely to disclose their HIV status? Why?

•How willing are methamphetamine users in this population to disclose their meth use to doctors and other service providers?

Information and Services Needed

•What are service providers in Atlanta doing to addressing the needs of methamphetamine users in the MSM community?

- HIV services
- medical providers
- legal services
- mental health providers
- addiction treatment
- other

•Which of these resources have been helpful? Which have not? Be specific.

•What barriers keep methamphetamine users from seeking assistance?

•Do you think that people in this population know about these services?

•Are these services coordinated among providers?

•Are there prevention programs to address methamphetamine use? Prevention programs to address the spread of HIV among methamphetamine users? Where do these occur? (explore school, jail, community centers, advertisers)

•What prevention needs remain unmet?

•What resources would you need to address these problems from your position of responsibility?

Recruitment Strategies

•Where would you find MSM methamphetamine users who were at risk for becoming HIV+?

•What methods would you use to reach these persons?

Advertisements (Billboard, magazines, radio, etc.)
Handing out Flyers
Community Information Forums
Online

•What other ways would you suggest as ways to get people in the MSM community to participate in activities that would address the problems of methamphetamine use and HIV?

•How might medical doctors and other service professionals assist in recruiting the MSM community who are HIV+ and use methamphetamine?

•Why would motivate medical doctors and other service professionals to want to assist in this endeavor?

Appendix D

The Intersection of Methamphetamine Use and HIV: Investigating the Impact among Atlanta's MSM

Focus Group Questionnaire (Former Users)

Impact of HIV/AIDS on community

•How have you seen the use of methamphetamine (crystal, meth, tina, etc.) impact the MSM (Men Seeking Men) community of Metro Atlanta in terms of HIV/AIDS?

•Is it getting better or worse? What is changing?

•Among HIV+ men who seek men, what behaviors are you seeing that you can attribute to methamphetamine use?

•In your opinion, what future trends should MSM in Metro Atlanta expect in regards to methamphetamine usage and the prevalence of HIV?

Risk Factors

•Demographically, how would you describe the MSM methamphetamine users in Metropolitan Atlanta? (Explore ethnicity, age, socioeconomic status, education, disability status, veteran status)

•What other medical and mental health problems do you see among methamphetamine users in the Metro Atlanta MSM community? (HIV, Hep A,B,C, specific mental illnesses, other health issues.) How do these factors impact their attitudes and behaviors?

•Among Metro Atlanta MSM methamphetamine users, what would make someone more or less likely to contract HIV?

•How does methamphetamine use impact at-risk behaviors among gay men who are already HIV+?

•What do people say in the MSM community about those who use methamphetamine? Are they seen as more or less likely to be HIV+? Does this matter to those in the MSM community?

Information and Services Needed

•In the Metro Atlanta MSM community, what resources do HIV+ methamphetamine users utilize? Which of these resources have been helpful? Which have not?

•What services are not being provided that are still needed?

•What barriers keep MSM methamphetamine users from seeking drug/alcohol treatment? What barriers keep them from receiving HIV treatment services?

•Are there prevention programs to address methamphetamine use? Where do these occur? (explore school, jail, community centers, advertisers) What prevention needs remain unmet?

Recruitment Strategies

•In Metro Atlanta, where would you find MSM methamphetamine users who were at risk for becoming HIV+?

•What would be the best way to reach these persons?

Advertisements (Billboard, magazines, radio, etc.)
Handing out Flyers
Community Information Forums
Online

•What unique strengths do HIV+ persons have that may help them quit using methamphetamine?

•What would you suggest as ways to get people in the MSM community to participate in activities that would address the problems of methamphetamine use and HIV?

The Intersection of Methamphetamine Use and HIV: Investigating the Impact among Atlanta's MSM

Focus Group Questionnaire (Community Professionals/Key Informants)

Title: Examining the Relationship Between HIV and Methamphetamine Use Among Men Who Have Sex with Men (MSM)

Principal Investigator: Dr. Brian J. Dew

Sponsor: Georgia Department of Human Resources, HIV Prevention Services Branch

The following questions are to be used by the group facilitator with the Service Providers and Public Officials Focus Groups.

Impact of HIV/AIDS on community

•How has methamphetamine use impacted the prevalence of HIV/AIDS among the MSM community in Metropolitan Atlanta?

•How has this changed over time?

•How has methamphetamine usage impacted your ability to serve the HIV+ MSM community?

•In your opinion, what future trends should Metropolitan Atlanta expect in regards to methamphetamine usage and HIV seroconversion among gay men?

Risk Factors

•Demographically, how would you describe the MSM methamphetamine users in Metropolitan Atlanta? (Explore ethnicity, age, socioeconomic status, education, disability status, veteran status)

•What co-occurring issues do methamphetamine users typically have? (HIV, Hep A,B,C, specific mental illnesses, other health issues)

•Among gay methamphetamine users, what risk factors increase the likelihood of becoming HIV+?

•How does methamphetamine use impact at-risk behaviors among gay men who are already HIV+?

Information and Services Needed

•What resources have you utilized to address the problems of methamphetamine users? Which of these resources have been helpful? Which have not?

•What prevention needs remain unmet?

•Who are the most effective providers in treating methamphetamine uses? Why?

•What barriers keep methamphetamine users from seeking treatment?

•Are there prevention programs to address methamphetamine use? Where do these occur? (explore school, jail, community centers, advertisers)

Recruitment Strategies

•Where would you find MSM methamphetamine users who were at risk for becoming HIV+?

•What methods would you use to reach these persons?

Advertisements (Billboard, magazines, radio, etc.)
Handing out Flyers
Community Information Forums
Online

•How might medical doctors and other service professionals assist in recruiting the MSM community who are HIV+ and use methamphetamine?

TABLE OF CONTENTS