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Methamphetamine Use in NYC: Tracking Trends, Identifying Needs

Report from Panel Discussion and Open Forum

While data are sparse, recurrent or continuing epidemics of crystal methamphetamine ("meth") use have been associated with poor health outcomes, including HIV and sexually-transmitted disease (STD) acquisition and onward transmission, neurocognitive deficits, psychological issues up to and including psychosis. All of these poor health outcomes are exacerbated by criminalization, stigma, discrimination, and the lack of a strong evidence base for therapeutic approaches which could include symptomatic treatment, detoxification, harm reduction through substitution therapy, and/or drug cessation. The legal, policy, scientific, and community contexts often contribute to isolating meth users and making it harder for them to access these services or to facilitate recovery and re-entry into productive society and full functioning. Earlier this year, New York City Department of Health and Mental Hygiene (NYC DOHMH) announced a funding opportunity to community-based organizations to provide services including safe spaces, linkage to medical care and social services, and harm reduction to New York MSM who were having problems with meth use. This symposium, cosponsored by DOHMH, the Lesbian, Gay, Bisexual and Transgender Community Center (LGBTCC), and Treatment Action Group (TAG), was held to further deepen and broaden the conversation among all stakeholders on how to more effectively address the needs of this population.

Identified gaps (services)

Challenges of front-end work:

- People call in seeking treatment but never make it for an appointment.
- People seeking help for methamphetamine abuse report experiencing mistreatment or insensitive care in the emergency room.
- Detox isn't always long enough, forcing someone to be moved too quickly into post-detox recovery, which compromises both detox and later recovery.

A higher level of care is needed but not always accessible to people using meth. Inpatient programs would be ideal, but if the individual doesn't have insurance or is undocumented, there are few to no options available to them.

Support groups are frequently geared toward white gay men and most service providers are white, so black gay men and men who have sex with men but do not identify as gay do not have the resources or support to curb or eliminate meth use. (In general, resources for these services are lacking.)

In gay "chemsex" culture, methamphetamine use results in a level of disinhibition and pleasure, particularly in sexual encounters, that people struggle to either recreate or try to forget after entering treatment for meth addiction. There may be alternate treatment options to reestablish sexual pleasure

after meth addiction and reverse neurological damage, but possible options are under-researched. Talking groups among former meth addicts could help reframe and rebuild sexual connections.

- Due to the belief that one has had the best, most uninhibited sex of one's life while using meth, it may become very difficult to give that up and try to relearn or value sex without meth. This may be particularly true for people who have been marginalized, or when that sex has been associated with disinhibition from decades of normative messaging around safer sex and the condom code (which themselves in many cases have not been modernized to include treatment as prevention [TasP] and pre-exposure prophylaxis [PrEP] as evidence-based safer sex practices).

People closely tied to meth addicts often have limited support or advice about how to support and deal with their loved one who is abusing meth to try to figure out how to be in that person's life. Thus the stigma associated with meth use affects both the user, former users, and their loved ones, friends, and family members.

Identified gaps (policy)

Issues with insurance: Uninsured people are not able to seek care, and necessary treatment is not always covered long enough by insurance to make a significant difference in the recovery of someone struggling with methamphetamine addiction. The lack of established, evidence-based standards of care for the various stages of detox, harm reduction, symptom management, substitution therapy, drug cessation, and necessary ancillary services makes it harder to obtain good care in many cases.

Identified gaps (services and policy overlap)

There is a lot of red tape to connect people to services, which is problematic in this population. The threshold for entry into recovery programs needs to be exceptionally low. Programs need to incorporate multi-step treatment approaches, with "a place that's safe to land" as a first step. If DOHMH can successfully implement this proposed model and get better program data, we can help set better models for the future.

Meth use can isolate people from the broader world while creating an insulated community. People aren't connected to services, and often become less connected, either by choice or by rejection or fear of stigma, to the larger gay community. One way to try to reach these people and learn more about their behavior and needs is to sample populations on Grindr and other geosocial networking apps to find people who aren't connected to more traditional community or health services, and get a better picture of the social networks created by methamphetamine use.

There are some potential treatments for neurological damage caused by methamphetamine use (such as Ibogaine), but they require clinical trials to be approved for therapeutic use in meth recovery.

The conventional wisdom is that people don't overdose on meth, and aren't in any danger during the withdrawal phase from meth abuse, so they don't need a spot at an in-patient treatment facility. However, many patients in crisis really do need care at an inpatient facility, with de-escalation to

outpatient afterwards. That handoff needs to be well-coordinated so that people are not lost in the process, which probably requires reform in how insurance companies conceptualize and cover treatment for meth users. Managed care changes are resulting in a potential patchwork of how care is covered and how people access services.

Stigma

Could some of the stigma associated with meth use come from the messaging used in public service announcements of the late 1990s and early-to-mid 2000s? We should be careful about how we frame meth use in social media and advertising campaigns. The last thing we should be doing is compounding the difficulties faced by MSM using meth by promulgating stigma, shame, and isolation.

An exclusive focus on harm, danger, and "sluttiness" of sex may increase stigma, which could have the effect of increasing meth use in an effort to dull the anxiety that surrounds gay sex.

Stigma, fear, and lying or deceptive behavior are intertwined, and one challenge is to work with people who can reach the meth-using population but might not necessarily be credentialed in ways recognized by the health/medical establishment. Solutions to meth addiction can only be found when people feel safe to disclose and work with providers and service organizations.

Meth use may in some cases be associated with violence and anonymity of sexual experiences, perhaps particularly for older MSM who have experienced enormous trauma and stigma. Some older MSM may have been traumatized by the suffering, loss, fear, stigma, and persistence of the HIV pandemic, but that also means that they have survived and are resilient, which may help them to create a more resilient frame for healthy living in the present and future. Also, despite gains, it is still hard to be a young gay man. The challenges might be different, but there are still challenges.

Advice

What are some good non-stigmatizing ways to prevent young people from trying meth?

- Tell them the truth about how addictive it is. However, because adolescent brain development craves risk, the focus is sometimes better put on reducing harm (i.e., preventing injection meth use, etc.).

For people experiencing euphoric recall associations, particularly in sexual situations, are there data on how long how long those associations last?

- Meth leaves your system pretty quickly, but dopaminergic centers of the brain come back more slowly, and usually return to "normal" within a year, depending on the amount and pattern of meth use.

What can we do for people who don't want to stop using meth to minimize risk?

- Adequate hydration and nutrition;
- Prevent catabolism;
- Learn how to recognize the warning signs for psychosis;

- Access to sedatives (benzodiazepines and/or drugs such as eszopiclone [Lunesta] or zolpidem [Ambien];
- Help the person create a lifeline and support system for if things do get out of hand to prevent isolation.

Next steps

Explore new treatment options, including NIDA funding for treatment option trials. Also, include translational researchers in conversations about potential solutions to meth abuse. ACT-UP has developed research agendas in the past, and would be interested in developing a research agenda for meth research, as well a political campaign to force funding of this issue (along with more visibility). Since the symposium, the ACT UP Crystal Meth Working Group and TAG have begun a study group to create such a research agenda and recruit interested scientists, regulators, and providers.

Continue to be mindful of stigma when developing social media and advertising campaigns.

Protocols to develop:

- Protocols for more sensitive and knowledgeable care in the emergency room for meth users;
- Protocols for harm reduction if someone doesn't want to stop using immediately
    - Including a checklist for what a meth user needs to do to stay alive/stay safe, and another checklist about what to do if someone starts hearing voices;
- Protocols for dealing with insurance companies to get the best possible care for someone using meth;
- Protocols to look at combination interventions: How can we operationalize existing research, and how can we fund further research?

The combination meth strategy needs a clinical/community advisory group as well as a community advisory group, which DOHMH will pursue with the contracted organizations.