

**Briefing: Update Panel on Crystal Methamphetamine:
Research and Community Perspectives
March 14, 2005**

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MALE SPEAKER 1: Welcome back to the second portion of our morning's panel [inaudible] Crystal Methamphetamine Research and Community Perspectives and we have a stellar panel for you. Before that there were some folks who joined us after this morning's session breakout and breakup so we want to give you an opportunity to introduce yourself, if anybody has come in and would like to identify themselves. Okay so we have four panelists with us. We have Jay Dagenhart from the Philadelphia Crystal Meth Task Force, Dr. Gordon Mansergh, from the Centers for Disease Control, Leo Rennie from NASTAD and Dr. Barbara Warren from the New York City Gay Lesbian Bisexual Transgender Community Center. I'm just going to briefly open it up by saying that I guess the issue of Crystal Meth has gotten a lot of attention lately. I think it is really important for us to put it in perspective and to be able to tone down the sensationalistic content, which is being presented in the media. I think it can do our community a great deal of harm. Not everyone in our communities are using Crystal Meth and having lots of wild sex and I think we need to keep that in perspective. I think also we need to understand the social context under which Crystal Meth is being used by our communities and the meaning that people are assigning to Crystal Meth use. Certainly I think if you're a youth who is homeless and

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trading sex for survival Crystal Meth might keep you from getting hungry and needing a place to sleep. Certainly I think we need to keep all of that in perspective as this panel discusses the issue of Crystal Methamphetamine use and with that said I am going to then turn it over and Gordon is going to go first. Thank you.

DR. GORDON MANSERGH: Thanks very much I'm really happy I had the opportunity to speak to you this morning about this very important issue. Before we get started I want to say CDC had a two-day consultation in January to address this issue. While other agencies have addressed it before we had a very unique perspective on the consultation. We were focused specifically on the association of sexual risk behavior and methamphetamines use. We broaden it as much as we could beyond just MSM but the literature is really strong and really shows the connection for MSM where it doesn't so much for heterosexuals or the limited data that are available doesn't suggest a real strong association there. Today I sort of pulled it back toned it down just to focus exclusively on MSM although so you know there is a broader context for the research. So what I'm going to do is talk a little bit about basically represent today is two and half days down into fifteen minutes to give you a general feeling of what the consultation was about and then at the end talk a little bit about what CDC is currently doing and

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then maybe share some of our preliminary recommendations from the consultation with you which aren't actually available yet but they are in the works. I have some preliminary comments to make about that.

So the structure I'm going to use today is talk a little bit about the background of methamphetamines use, prevalence of Meth use. Meth and sexual risk behavior, meth and how it is associated with STDs and HIV infection. Specifically about motivations and context of Meth use to which the moderator just said is a very important factor to keep in mind and drug treatment as a form of prevention to reduce sexual risk behavior. I'm going to talk a little bit about some of CDC's current activities.

Do you know whose computer this is that I'm using? Is it your computer? The screen okay thanks. I appreciate that.

Okay so just to give you a brief history, amphetamines are a Central Nervous System stimulants first synthesized in 1887 and methamphetamines specifically was emphasized in 1919 both methamphetamines increase neurotransmitter activity. They were used during the World War II for energy producing and anti-depressant properties with soldiers and what've seen since that time is sort of three ways of Meth use in the US history. In the 1950s, the late 60s and 70s and then the current wave of use that you

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saw started in the late 80s and primarily in the early 90s and as we know it has been moving from West to East. We see on the East Coast what've seen on the West Coast for a number of years now. It has been used clinically to treat Narcolepsy and ADD and obesity.

Now the effects of Meth and the signs of its use at low and moderate levels are lack of appetite, insomnia, rapid speech, hyperactivity, increased heart rate and blood pressure, dry mouth, increase confidence, lower sexual inhibitions, at the same time impotence. At higher continuous levels we see paranoia, hallucinations, violence, isolation, anxiety, irritability, stroke and even heart attacks. Now the effects can last from four to twenty-four hours at a relatively low cost and that depends on the quality of the product. Meth use is often followed by depression, which makes it a very highly addictive substance. So to talk a little bit about the prevalence we have some indicators of prevalence from various studies that have been done. A San Francisco Young Men's Health Study that was done in 92 or 93 that data are from was among young men from the age of 18 to 29 and in that study they found that within the past year 30% of men had used Meth in that time period, another indicator from the HIV Cero Positive Urban MSM Intervention Trial also known as SUMMIT. The data from that study was collected in 2000/2001. This data are in press at

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this point. This study was actually done in San Francisco and New York and it was at an opportune time to see sort of differences in prevalence in 2000. Eighteen percent of the men in San Francisco had used Meth in the prior three months where in New York City only 7% of the men had reported using in the prior three months. I imagine it is quite different now at this point in time but at least at that point we see sort of almost the dynamic of the West to East going there. Also the same years, 2000/2001 the San Francisco Prevention Messages Study which was done among both positive and negative MSM. Actually a very diverse sample that had roughly a third Latino, a third African American and then sort of everybody else in the other third. We found that 15% of the men specifically during their most recent anal sex encounter that 15% had used Crystal Meth during that specific encounter. This was third only to alcohol and marijuana. In addition to that we also found that 17% of the men have used methamphetamines during anal sex in the past three-month window. Another indicator is from the HIV Testing Survey, which is a CDC Study that was done also in 2000/2001. It was done in fifteen sites around the country so this is more of a National perspective on Meth here. We see that overall of HIV negative and HIV unknown men in the past twelve months 18% had used Meth and among HIV positive men 19%. There were differences by race and ethnicity and by age group. African

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American men had lower prevalence of Meth use in the prior year verses the other groups and younger men had actually a higher prevalence of Meth use in the previous year. So specifically looking at research and the link between methamphetamines and sexual risk behavior I have a couple of indicators to share with you here. This again is from the SUMMIT Study, New York/San Francisco 2000; Meth use was associated specifically with unprotected receptive anal sex with a casual partner in the prior three months such that positive Meth users were two times as likely to report unprotected receptive anal sex with their HIV negative partners compared to non-meth users. In terms of with HIV unknown partners or partners who zero status they didn't know was 2.3 times as likely and then with other positive partners it was more than 4 times as likely to report un-protective receptive anal sex. So what we see from that is a very strong association cross partners with receptive anal sex risk. They also did find among the unprotective insertative anal sex with casual partners in the past three months that with their HIV partners they were 2.8 times as likely to report unprotective insertative. This dynamic was not found with HIV unknown or HIV negative partners. Now specifically with the situational link of Meth use and sexual risk again this is from the Prevention Messages Study and we actually found that unprotective receptive anal sex MSM who used meth

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before sex were 2 times as likely to report that behavior. There are also 2.2 times as likely to report having had specifically discordant unprotective receptive anal sex. That is unprotective receptive anal sex with a partner with opposite or unknown zero status, so the same dynamic for specifically in a last encounter. We didn't find this association at all with insertive with Meth use however, interestingly to share it with you here; Viagra use was very highly associated with unprotective insertive and specifically discordant unprotective insertive anal sex during that anal sex encounter.

Now the link between meth use and STDs, this is data from a study from the San Francisco Health Department specifically from their STD clinics. It's a study on MSM there. They found that meth users verses non-users to have twice as many partners in the prior four weeks. They were 1.7 times more likely to test positive for Gonorrhea, nearly 2 times more likely to have Clamydia and nearly 5 times more likely to have Syphilis. Other Health Departments and other STD jurisdictions in the country have found that in recent years an increase in meth use associated with Syphilis cases among MSM.

Now concerning meth use and HIV again from the Messages Study, from that HIV positive men were nearly 3 times as likely as HIV negative or unknown zero status men to

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report meth use during their most recent anal sex encounter. An interestingly recent study in New York City found basically the identical findings, three times as likely. San Francisco MSM, STD clinic study that I just mentioned they found that their STD Clinics that meth users were 2 times as likely to be HIV positive than non-meth users who attend their STD Clinic. So what I've just described to you are the sexual behavior association with meth use as well as bio-medical factors of STD infection and HIV prevalence so we see a real clear relationship there. Not only do we see it in behavior and bio-medical indicators we also see it in MSM verbalizing this. An interesting study that was done in Southern California, qualitative study of HIV MSM meth users in California identified five main reasons for using meth. The number one reason was to enhance sexual pleasure. That was reported by 88% of the MSM in that study and again this is HIV positive MSM specifically. Now the same authors did a quantitative study a year or two later with HIV negative heterosexuals so you've got two different populations but we can try to see if there is any difference there. In this quantitative study the top three reasons for using meth, sexual pleasure or sexual anything was not mentioned at all. So you can see from the similar approach that these authors took to address this issue that they didn't find anything really associated for heterosexuals.

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Now in terms of context of meth use in the mid nineties in Seattle there was a study done called, The [inaudible] Sound Meth Study and they found that there primarily five MSM sub-user groups at that time. One was a group of guys that were associated with sort of party circuits. From the description of the study it wasn't necessarily circuit parties but it was party circuits that you know were circuit parties. In the bath and sex club network there was meth use in transgender circles there was meth use. Among young adults or youth circles and these are primarily straight or club scene oriented youth circles. And then self-medicating HIV positive men were another circle. These men were often homeless, depressed and injection drug users as well. In another study that was done in 1999 in San Francisco which was among men who attended a circuit party in the prior year, we found that men had used meth during a party weekend where nearly 2.5 times as likely to report having discordant unprotected anal sex during that party weekend and we also found that meth use is more prevalent among these guys during circuit party weekends compared to other weekends for them. This is especially true for Circuit parties that they went to that were away from their hometown. So we had actually looked at their behavior at their most recent party out of town, the most recent party in their own hometown and then other weekends for them.

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Now to address effective programs that have been studied scientifically, there's been a study that is in press right now by Steve Shoptah [misspelled?] and Kathy Rebeck [misspelled?] which I'm sure many of you have heard of in Los Angeles. They looked at basically their study design was to look at four different arms of treatment, different types of treatment and compare them to each other and their effectiveness. One of the arms was specifically what we call, Standard of Care, which is cognitive behavior therapy approach. A second arm was a continuous management approach, which was a Voucher Reinforcement Approach for clean urine samples taken three times a week. The participants would receive a voucher that they could then exchange for goods and services. The third arm that had a combination of those two and then the fourth arm that was specifically gay cultured or tailored cognitive behavior therapy approach. They used gay reference throughout their experience. Basically they found that all four of the arms were as effective as each other. All four of the arms at four months post base line, six and twelve month follow-up found decreases in meth use, recent unprotective receptive anal sex, recent unprotected insertive anal sex and recent number of partners. And again there was statically no significant difference between each of the four arms.

So to summarize overall meth is a significant public

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health concern. Meth use is relatively prevalent among MSM. The use is linked to sexual risk behavior and HIV/STD infection among MSM and motivations and context meth use should be taken in account when designing programs and that we also know that meth treatment can be effective in reducing sexual risk.

So some related CDC activities that are going on right now and what I mentioned already was the consultation in January. We are in the process of finalizing the summary of that consultation and developing recommendations in both the areas of research and programs. I want to share with you a study that is currently in the field. It is actually starting its third years called, Project Mix. It is a study that test six-session group intervention to reduce sexual risk behavior for high-risk subjects using MSM. This is a unique program as we are testing in a randomized trial format and intervention that focuses specifically on de-linking substance use and the sexual risk for MSM. It would take me hours to explain it to you but basically it is in the field right now. We're actually in our third month. The trial will be in the field for the next three years. It is also interesting in terms it mixes very diverse groups. In terms of HIV Cero Status we have positives and negatives together in the same groups addressing issues by race ethnicity we're targeting a third African American, a third Latino, SES we're finding is very diverse as

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well. It is non-gay and gay identified participants. Drug of Choice, this is not just a meth intervention it is any substance. It is obvious that we're finding meth is quite commonly the substance of choice but to treat meth singularly in a prevention program doesn't seem to make a lot of sense as a lot of switch-hitting can happen out there. In terms of pattern of use, we have men along the entire spectrum who had maybe one instance of unprotective anal sex with substance use in the prior six months to men who technically could be addicted and it's constantly an issue for them. So again we're currently in the field in Chicago, Los Angeles, New York City, and San Francisco and just to wrap it up some other activities that CDC are doing is behavior surveillance has become a top priority specifically with looking at meth and sexual risk. The National HIV Behavior Surveillance Project which last year just started with the MSM specifically. The first year of the project MSM was the first population to focus on. So those data should be available soon. The HIV Morbidity and Monitoring Project, which is relatively new, specifically looking at meth use and sexual risk and also there is a web-based component. It is in a pilot study format at this point for the National HIV Behavior Surveillance Project. Program wise - funding agencies such as NASTAD and other agencies are starting to do a lot in this area. Technical assistance and training is available through one of our branches at CDC. Then

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other activities, a couple of things specifically I would like to mention is, one is that we recently briefed the CDC Hurst Advisory Council at their semi-annual meeting about this issue. They were very interested and requested to hear about this issue so we've had the opportunity to talk to them about what is going on. I know it is on their radar screen and they want to follow up their next meeting. Also the President's Advisory Council on HIV/AIDS, Julie [inaudible] just briefed them in their February meeting about the consultation, just in general terms that this consultation happened in January and specifically about Project Mix, that there is actually a study in the field to address this issue so it is on the radar screen at the President's Advisory Council level too. From what I understand it was a fairly well received. Thank you.

[Applause]

MALE SPEAKER 1: Thank you Dr. Gordon. Why don't we hold questions until the end and with that I'm going to introduce Dr. Barbara Warren?

DR. BARBARA WARREN: I'm assuming this is on, right? Okay great. Thanks Gordon that was a great synopsis since I was at that CDC meeting and there was a tremendous volume of information that was presented that Gordon tried to hone down into highlights. You did a pretty good job. What Gordon couldn't really capture in his presentation of the information or the facts was all the conversations that those of us who

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were invited to participate in this meeting were having about the information that we were sharing and presenting. There is bad news and there is good news. Then there is a challenge to us and I think it is particularly relevant to us a National Collation on LGBT Health because the challenge for us and I'm representing the sort of community based organization response today in responding to the Crystal Methamphetamine Crisis and the related crisis of HIV/STDs and the other effects of Crystal Meth use is really to maintain our compassion within our own community and to fortify our resolution without to keep resources to address this problem and not to let this issue sort of vilify or demonize gay, bisexual and other men who have sex with men in particular because one of the struggles we have now around highlighting this crisis is also the backlash that we can and have already gotten against the sexual practices of gay, bisexual and other men who have sex with other men and the responsibility sometimes that our advisories want to put on our community for the HIV epidemic and for irresponsible behavior. So that is the bad news. The other thing that happened shortly after we went to this CDC meeting and we all went back to our respective communities armed with a lot of information and some increasing concern was that the HIV virus strain issue came to light and hid in New York and I can tell you and other folks that are here from New York can tell you that we were

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just swept off our feet with both the interest of the press, the International Media and the controversy around what the possibility of this strain of HIV and so far there is no evidence that it is or it isn't it is still sort of in process but what the implications of this would be and again there is good news and there is bad news. The good news is that I think that we really needed some attention re-focused on the whole issue of HIV. The bad news again is that there is a and still be a tremendous backlash against our community, against sexuality in the community and sort of a demonization or a further marginalization of the community particularly gay, bisexual and men that have sex with men. So I think for a lot of us particularly as we look within and struggle with this challenge. Crystal Methamphetamine and I am going to talk in the perspective of a person who is very involved in this on the East Coast right now. We knew what was coming. I can remember conversations, I'm looking over there at Joe Nice and I can remember conversations that he and I had like three or four years ago where he said oh my god, you know we are enodated with this Crystal Meth crisis in San Francisco and I'm warning you Barbara you do substance abuse work in the community in New York it is coming your way. It's going to be there. And we knew that and we also had so many other issues that we had to deal with that I think if there is one thing that I regret is that we didn't

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take on that challenge and we didn't do a proactive prevention campaign way before we actually started doing it. We actually started doing it when we saw some of the early data. Gordon mentioned the SUM Study in New York, the 7% figure. I've been working with Dr. Perry Helkedas [misspelled?] at NYU and his community based team and he was getting a lot of early data in his early studies that were indicating it was no longer at 7% that it was up around 20 and 30%. They just recently did some preliminary studies and they were interviewing. Instead of going to the club scene and the circuit party scene where of course you're probably going to see more drug use, they were going to the gyms in New York and they were interviewing men coming out of gyms in the middle of the day. I think the preliminary figures were around 28% of those men had used some Crystal Methamphetamines to enhance their workout. So clearly we've got a challenge before us. One of the things that we talked about of those of us who were together at the CDC was the challenge and the concern around the absolutely the irrefutable fact that Crystal Methamphetamine use insects with HIV risk and definitely causes new cases of transmission. Also we know that they're a lot of questions about Crystal Methamphetamine in terms of immune suppression in people who are already living with HIV. There are some questions and some examination going on about, does it cause

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increased replication of the virus, how else can it affect? It definitely interacts with antiretroviral medications. So there are lots of reasons why people both positive and negative in our communities and in the communities that we serve and other infected communities should be on the watch out for this drug and the intersection of this drug with HIV related concerns.

This drug though in communities where there isn't that much HIV concern is also a killer. Fifteen to twenty percent of all chronic drug users in Hawaii and even in places on the West Coast and now in some places in Middle America report Crystal Methamphetamine as their primary drug of abuse. This is in heterosexual populations.

It is interesting that Gordon talked about the sex connection. Here is where I want to kind of bring the issue together and connect the dots. How come then when you interview straight men and he pointed to one study they don't put enhancing sex as one of the top priorities. Well I think that has less to do with whether or not they use it for sex and a heck of a lot more to do with the cultural and political context that gay men live in verses straight men. I think the reasons that this behavior is still such a challenge gay, bisexuals and other men that have sex with men is absolutely linked to the absolute hostility and demonization of gay sexuality in our society and that this is

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kind of a way to using a drug like this and engaging in these behaviors is a way to kind of forget that. Anybody that has ever used Crystal and we have some folks that can talk about that probably better than I although it is one of the few drugs that I did use and I used it when I was in college and I remember very well how it blotted everything out except the moment and what a powerful, powerful drug it was. I used it to study and lose weight and that was my compelling reason at the time. I also remember the effects of trying to get off of it and I will never forget that. It's a really, really difficult substance to get off of physically, emotionally and in every which way. But I think we really need to understand and to have compassion within the community instead of saying why don't gay men know better, you know what's wrong with gay men? Why are we continuing to do this to ourselves? I think we really, really need to understand that we have to have a lot of compassion for the struggle that a lot of folks in our community are undergoing around the political context that we're dealing with right now and with how tiring it gets you know 20+ years of dealing with an epidemic. In dealing with an epidemic that not only impedes your freedom of expression around your sexuality but also has brought a tremendous amount of pressure to bear and a tremendous amount of resources in our communities. It is very fatiguing and then you know all the stuff you heard this morning that you have

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to fight against so it is sort of understandable how it is a social setup and a political setup. Also we have to remember that HIV is a virus and viruses replicate. That is what they do. That is how they survive and so regardless gay, straight, green, pink, the commitment to studying how we can erradic this virus is the real issue. You know, 87 billion dollars in Iraq would have gone a long way to erradic a virus.

The other thing is that drug addiction is not a gay problem. The challenge for drug prevention and addiction is a worldwide problem. It is in all of our societies right now and for those of us at the community level you know this is sort of the latest manifestation but it has a political, social and culture context that we can't ignore.

Then finally I think going back to New York, one of the things that we all looked at when we heard both the good news and the good news at the CDC was and Gordon talked about Kathy and Steve's research. One of the things that we talked about, he sort of presented no significant difference but one of the things we all talked about was Wow if we can buy cultural competency, in other words you know the fact that Kathy and Steve showed that when you work with gay, bisexual and other mean that have sex with men in the real context of their lives it is effective. Contingency management, which doesn't mean giving, people thousands of dollars to stay off

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drugs. They gave them twenty dollars vouchers and by the fourth week they didn't have to give them the vouchers anymore. They were already off the drug and were kind of committed to staying in the treatment. By giving them good cognitive behavioral therapy group treatment and there is other people [inaudible] can talk about looking at some pharmacologic treatments that their experimenting with. By combining all of these things you have a powerhouse of an effective Crystal Meth and other treatment programs that can specifically culturally targeted to gay, bisexual and other men who have sex with men. So that was the good news.

The bad news is that we're going to need the resources to do that and we're going to need to be able to again keep out the hand of compassion with the effective tools and not engage in bashing our own community and to also make sure that the force is out there that will conspire to use this against our community that we build coalition with other affected communities and make sure that doesn't happen. So we have a lot of work to do. We desperately need resources. I will just quickly say before I pass it on to Jay that there is good news and bad news in New York. The good news is that our New York City Department of Health and now our State Assembly now have been responding to this. The bad news is they are giving us these sort of short-term one-time only little bits of funding that don't even begin to

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address the ongoing need. We need ongoing prevention. We need ongoing treatment, etc. So you know, we're working on that and we heard this morning again like all the other demand and challenges that we have. So we have an opportunity here but we also have a challenge. Thank you.

[Applause]

MALE SPEAKER 1: Thank you Barb and now Jay Dagenhart from the Philadelphia Crystal Meth Task Force.

JAY DAGENHART: Good morning everyone. I guess I'm here today to talk to you from a perspective recovering addict and our reaction in Philadelphia as a group of recovering people who have come together to fight this very difficult problem within our community. It is interesting, I was asked to sit on a panel this Wednesday in our community, the Mazoni [misspell?] Center and Philadelphia is putting together a forum and it enabled the City Office, David's office and us as recovering addicts to come together with our service organizations to look at this problem and to fight the problem within our community. What is interesting is that they ask me to do a bio to sit on this panel and immediately I was a little insecure about it. I was looking at these bios of all these different people and all their great accomplishments and what ended up happening was my bio turned into all of my losses because of this drug and everything that has happened to me because of the devastating

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effects of Crystal Meth. Because of Crystal Meth and my addiction which started in 1999 and I've just celebrated a year of sobriety. [Applause] Thank you and you have no idea, it's like the most difficult thing I have ever done in my life. It was very difficult to get off the drug. I've been in about eight to ten rehabs whether it was Cocaine addiction or Crystal Meth. In this bio as I was saying I was listing all the negative things that have happened to me one of which is becoming HIV positive, one of which is losing just about every job I have had during my addiction. Being gay bashed, having a gun pulled on me, declaring bankruptcy and finally becoming homeless all of because of my Crystal Meth addiction. And what is so interesting in the distorted mind I had at the time of my addiction that, I walk a fine line in calling myself a bug chaser but I was definitely engaged in unprotected sex repeatedly in bathhouses with men who to my eye were experiencing wasting. That I would engage in sex with them and have them ejaculated in me in hopes of becoming positive. So you know, I was pretty much a bug chaser but the drug gave me a sense of wanting to dye. In today's time you know, it is not really the case because of medications that leads to the complacency that we're dealing with in terms of gay men. So what did we did in Philadelphia was a group of recovering of addicts came together and we formed the Philadelphia Crystal Meth Task Force. We took an image

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that was taken of me after I tried to commit suicide and I jumped 33' into a construction site here in D.C. I had steel sutures put in my head and I looked really awful you know and a friend of mine ask me if he could take a picture of me when he picked me up from the emergency room so I could remember one day how awful or what a very low time in my life was, so I would have a constant reminder of where I had been. So we took that image and we took what Peters Daily had done in New York with the HIV Forum using the images of bury in your face marketing in the gay community in a sense that we're tired of pushing this under rug and we're tired of not discussing it so we're going to talk about it in very bold ways to change the conversation. Oppose to a group of gay men on a Sunday morning reciting their antics of Saturday evening and endorsing each others behavior of unprotected sex or dancing out all night to say I did a couple of bumps of Crystal Meth and having it be inappropriate behavior and say are you an idiot? Do you realize how addictive this is? Do you realize the things you can loose or you can become positive. What they tried to do in New York and I think they have done very effectively is to change the conversation and we've tried to take that same model and that is what we did in New York. We took this picture of myself that was taken after I tried to commit suicide and we spun off from a little of what they did in New York plus a National Campaign and our website is

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called, Meth2death.org and basically there are about six lines of text. The first line says, Sixty dollars for Crystal Meth Tina. The second line is having sex while high free. The third line is, becoming HIV positive while high free? The next line is, Emergency room visit after attempted suicide, \$2500.00. One week of Rehab after that attempted suicide that is \$15,000.00. A lifetime supply of HIV medications is \$200,000.00 and the last line is loving yourself enough to stopping using Crystal Meth Tina is priceless. So that is the campaign that we've done and you know we have luckily partnered with the Mazoni Center in Philadelphia and they have helped pay for our posters. We're in the midst of trying to get a 501C3 Status but they're kind of being our financial godparents right now until we can do that. And the Mazoni Center is putting on a Community Forum this Wednesday in Philadelphia so it has been interesting and it has been a wild ride working with journalist. There was a story that came out about me in the Philadelphia Weekly called Outing Tina and erotically it came out within the same week of this new strain of HIV so it is jus like all of this attention and everybody trying to disseminate all this information about what exactly is this new strain of HIV and how does it relate to us as recovering addicts and what is the message that we should be putting out there with not a whole of knowledge about what the facts are. So we see a lot

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of people in our community not dealing with this drug and just continuing pushing it under the carpet and so we hope to change those conversations and deal with it in very bold ways going forward to educate our community whether that is outreach in the bathhouse. One of the things that I think is so interesting is about two or three months ago I went into the bathhouse and keep in mind I'm a single gay man and I have sexual needs so I go out and I can't go to bars and I can't go to clubs because there is drugs and alcohol there so I go in the hopes of being touched, the desire to be touched by another man is a very basic need that I have. So I got horny so I went to the bathhouse and when I disclosed my HIV status in a bathhouse there is probably six men that I encountered whether I came onto them or they came onto me and I disclosed my HIV status to the first five men. All five men A) didn't ask me if I was positive or B) didn't tell me their status and then once I did tell them my status they turned and walked away from me. And the only person that was willing to have sex with me was the Crystal Meth addict. And this is not mystery. No drug dealers in our community are setting up shop in bathhouses. They check into a room, they bring their supplies and they can feed their sexual addiction which is stemmed from their Crystal Meth addiction and they can sell large quantities of the drug without fear of getting caught because from who the DEA or the police or what have

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you are going to come into the bathhouse to walk around in a towel with the fear of playing grab ass for a lack of a better expression and crack down on the drug problem within our community. I met with the DEA to talk to them about education and ways to educate the gay community about what happens when you buy or sell this drug because what is happening is young gay men who are starting to use Crystal Meth are starting to deal the drug at a very young age just to feed their addiction and when they do get busted they are self-destructing and they realize their whole life is just completely flashing before their eyes. So this is what we're doing in Philadelphia. It is all very new to us and every step is a new learning experience and stepping out and telling my story has been a liberating and very painful experience but I realize that when I started working with this journalist nobody was willing to tell their story. The fear is what is keeping it in the closet and keeping it in the bathhouse, not being addressed and you know we seem to focusing all of our concerns as a gay community of what I am observing is our rights and marriage and going forward but I'm noticing that my gay brothers and sisters are suffering from immense addiction and alcoholism that we can not seem to focus loving one another you know and I don't know how we can do that because with HIV we had a problem, this is how we came together to love one another. You know there was a

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problem and all of a sudden we had to become a community. I think the word community is very interesting. Here we're faced with a drug problem where we don't have a medication to help us with the problem so we have to come together and like mentoring one another or loving each other properly because you know as gay men we centralize everything and we shake hands with our penis. I think if we can learn to educate one another you know and help and bring the problem into the light we might have a little bit more success in dealing with this. So thank you for letting me tell you my story.

[Applause]

MALE SPEAKER 1: Thanks Jay and now Leo Rennie from NASTAD.

LEO RENNIE: Hello. Good afternoon I guess everyone. I want to try to talk a little bit about some of the policy responses that we need to be working towards on the national level and also on the state and local level because it occurs to me that a good share of resources go to the states in various forms and we pay a lot of attention in policy discussion as to what needs to happen in Washington D.C. but sometimes we don't talk about advocacy, policy, etc on the state level so I want to address that. So what I want to do is primarily get a reaction to my reaction to the CDC Consultation that Gordon and Barbara talked about. Secondly I want to talk about a Call to Action on Crystal Meth and Gay

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Men that we at NASTAD released with NCSD there are some in the back and I see some circulating around the table so I'm going to talk primarily about the eight policy recommendations that are included in the next Call to Action and the last I want to talk a little bit about the state level responses that I just mentioned that I think are important to pay attention to collectively.

First to the respect to the CDC Consultation, let me talk about positive strength and I will talk a little bit about some of the limitations that I saw that would fit. I think the first good thing was that it was very well attended. You had representatives, you had researchers, and major NAHA funded researchers from across the country, health department representatives, community group providers and federal officials. As far as I know I think it was the first organized response on the National level by HHS to look at Crystal Meth and Gay Men so that was a good thing also. In fact if you look at, I'll probably jump around but if you look at the first recommendation on the Call to Action we released we called for a National Coordinated Federal Response to Crystal Meth among Gay Men asking for all agencies within HHS to collaborate but what was good about this meeting in Atlanta was that CDC took that charge very seriously and organized the meeting. You had NAH very well represented of some of the other Federal agencies there.

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There was a focus on prevention and research as Gordon mentioned which I think is good because you really can't disconnect in terms of talking about this issue. There are other issues on the prevention side as well as the treatment side. There were some limitations in terms of intervention. I think the Project Mix that Gordon referenced will provide us with some good data and modalities in the long run around what we can do on the prevention but again that is a three year study. I think the good news from Chateau data that was presented that we do know that there are some models out there for treatment that can work for gay men. The report will be coming out. Let's just wait for the CDC to release that. I think that will be very good in terms of helping us to shape where we need to move forward with this epidemic.

Now in terms of some of the imitations again we think this is very important for all Federal agencies to play some role in responding to this issue. At that meeting, the Substance Abuse and Mental Health Services Administration (SAMHSA) was not present or at least not present in a significant way and that raised concerns by a number of the people in the group. There was a significant amount of resources. This is going to bring me back to my last point. In terms of looking at how SAMHSA dollars are going toward addressing this issue. You did have NAH presence and major research and major leaders in the Aid Research and they will

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place NAH with theirs so I think that was very good.

And last I think Barbara mentioned it. It was not much of a discussion about new resources being put on the table so again we're going to need more money to deal with this on the research, treatment, prevention sides. I think it sort of well I never think it is premature to call for more money. You always need more money but it is sort of hard to say what we would spend it on in the absence of knowing what works with respect to prevention of what works with respect to care. I think you can develop research addenda's. I think there are a couple of things we really need. In the short time you can say where money needs to go like surveillance and really figuring out where meth is being used and I will talk a little bit more about that. Having said that I think we definitely need more baseline information to sort of do planning and the shape where we want resources to go. Probably some targeted demonstration progress would be good also.

Now let me talk a little bit about the Call to Action and since we're on TV this is the Call to Action. This should be on Kaiser's website and in fact this has been on there for some period of time. It is also on our website and probably the NCSB website. Our website is NASTAD.org and you should be able to access it there. Let me talk a little bit about how we came to do this. NASTAD, we represent the state

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Aids Directors. These are basically individuals in every state and territory that is responsible for managing HIV and Aids Prevention Care Dollars within the state. Sometimes they manage other programs like STD or Hepatitis Control activities and other infectious disease areas. The long and the short story of it is as more data was coming out, as Meth and Gay Men became more and more in the media as our members soar the problem emerging in their areas they felt very concerned that NASTAD needed to have some roll on it. At the same time is that what's going on be forming an Adhoc committee of Aids Directors to begin looking at Gay Men and MSM issues more broadly and of course this Crystal Meth issue emerged as one. It was very important for us to address. We worked with the National Coalition of STD Director as sort of a sister agency our counterpart. These are the STD Directors and I think that connection was initially around Syphilis because obviously people were already seeing it across the country for at least four or five years now. They Syphilis outbreaks in cities. Syphilis among MSM this is a major problem. The National Syphilis rates are rising mainly due the male Syphilis cases and most of those cases are contributed to gay men so we know that there is a Syphilis problem among gay men. You know that there is Internet types of issues and then you knew of this overlay around Crystal Meth. All of this came together and you were working with

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NCSD on these issues and then we decided to do something on Crystal Meth. For the purpose of the time I won't go through each one of the recommendations one by one but I would encourage people to read it. I think that what we tried to do at NCSD, this is not like the end on the deal on what needs to happen with respect to policy around Meth and Gay Men. It is sort of a blueprint. We've would ask people to look at it as a blueprint. If you're asked well what does the National Response need to be, here is like eight items that you can begin talking about so we're trying to shape the discussion. If you think that a recommendation makes no sense please let us know. If you think there are things we need to add into it please let us know. So I just say that we're not trying to sort of own the agenda we just want to put something out as talking points or a starting point as a framework for us to move forward.

Some of the general things that come out like I said they're eight steps to it or eight points to it. Some of the major things I think I just want to reference are number one - the Coordinated Federal Response - and we talked about that. I've talked about it mostly with respect to HHS and the relevant agencies that are working together. One thing that did happen the [inaudible] with the CDC, HERSA Advisory Committee I think they met in November and at that meeting [inaudible] endorsed the Call to Action and they actually

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forwarded it to then Secretary of Health and Human Services, Tommy Thompson asking for him to look into and mandate all that all the relevant agencies to work together. I know that letter went and you know we have a new Secretary of Health and Human Services so I think one thing collectively that we need to do in this coalition and other coalitions is really follow up and look at what is Senate Secretary Leavitt doing with respect to this issue. Especially given that his Advisory Committee is on record as endorsing this concept. All of HHS working together. What is sort of related to this is that we need to figure out the appropriate roll of the Criminal Justice System in terms of dealing with this. There are a lot of gay men who actually do argue for [inaudible] controls this. There is nothing wrong with that. I think we need balance in terms of the agenda so there probably is no appropriate roll for the Criminal Justice System. The recommendation that we have in here is Number Six talking about really educating law enforcement around this issue and around the unique issues of gay men face. We definitely need to do that and also on the Federal level you know talking with the Department of Justice really coordinating and partnering with them. I'm not sure but there is certainly a roll in the area of the dialogue from the Criminal Justice both on the Federal level and the state level and local level even.

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Resources - I talked about this. We need money. We need money for prevention. We need the money for treatment, interventions. We need targeted resources of gay men where meth use is increasing and where you see clear examples of the association of risk behaviors. I don't think you need to show, I mean there is not a lot of data. Gordon went through the data. I think intuitively and until you can make a case from the collection obviously well this is preaching to the Choir. Obviously there is something going on here with respect to HIV transmission and that it is hard to show it. I got a call from a reporter actually who is well the questioning is sort of like, what is the data out there? How do we know that HIV is being transmitted? We know a lot. We may not know a lot you know scientifically or make it a policy but we know a lot of things for a real agenda around this justified the more resources for.

The last thing research, I talked about this a little bit. Apparently we look at NIH and CDC around research and certainly it needs to be targeted. Research and not just intervention development both are under prevention and to care side. I think it is a balance that is incredibly important. We need to understand nationally how Meth is being used among gay men and all sorts of populations. I think the racial ethnic issue is very important. Many people argue that this is not an issue for gay men of color. I

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actually think it is. I know gay men of color that are looking at this issue to access what is happening in their communities. So I think it is an issue for us to look at for men of color, for African American and Latino primarily in urban areas especially on the East Coast where we're getting a lot more attention to this but I don't think we have the data to demonstrate it yet scientifically. I think that a lot of the studies in California that began documenting this, those samples were not as diverse as they should have been. I think that the data is much different. His samples tend to be diverse and include populations of gay men of color in there so we know that this stuff has been going on there. For me it's a balance issue but I think we need to continuing looking at it and studying it so certainly more targets and resources for balance will be very much needed.

Let me talk a little bit about things that we are doing at NASTAD in addition to the Call to Action. This will be grabbing a couple of meetings. Excuse me. Wrap it up, okay. Well I have to wrap it up and that's fine. Sorry. We're doing two meetings this week. One is a meeting on National Gay Leadership. We really talk about a broader public health and wellness agenda for Gay men. That is not so much around Meth use but I think it is a broader sexual issue and how to be like being gay and stuff. Somebody mentioned that all we do is talk about marriage. How do we

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sort of do more around broader public health issues? Second we're having a targeted focus meeting for health departments around that is best practices for Meth use prevention for gay men. I will mention that after Association of Health Officials it is drafting a document where they look towards the restrictions and that's not ready for release yet but that's going to be very important document I think that we will have to ask the Representative to our meeting.

[Inaudible] is the state is sort of our counterpart agency. That will be a very important one when it comes out because we need to have clear guidance around what works around prevention and to be able to give guidance to states surrounding. Lastly the thing I wanted to say about state level again you need to look

SAMSHA and a good deal of their resources comes out to be a block grant and it goes to the state subsidy agencies again we spend a lot of time in looking at the Federal response but once those resources get to the state we need people on the state level need to sort of find out how much money is coming in the SEASAP and is it going towards this issue and you can plan it and advocacy and organize along that level. [Applause]

MALE SPEAKER 1: I wanted to thank Gordon, Barbara, Jay and Leo for their wonderful presentations and we'll open it up to questions. I think contact methods is obviously a

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movement at the Federal level, that we definitely do need more research and surveillance especially around gay men of color communities where there is this myth that they are doing other drugs. Crystal Meth is not entrenching on those communities and some of us that actually keep our ears to the ground realize that that is not true. I think also really, really important is to remember Barbara's message that we need to take this discourse and rescue it from the transition of mystic and homophobic group, which it has been placed because it demonizes a community of man. I think we need to stop being judgmental. I think Jay said because it does drive this stuff underground. You know as providers, as public health advocates, as folks working in Federal government or whatever we need to really be sure that the discussion is about what can I do to help you get off of this drug and not to close our doors to people because it does drive it underground and it doesn't do anyone any good. With that said I think the most important take home message I think again as Barbara said is do not wait for it to become a problem in your communities. The resources are obviously beginning to be seen. We have some movement on prevention. We have some movement in treatment. We have some data so get back and begin really I think look at your communities and leverage resources to begin to address this issue before it does become an epidemic in other cities. With that said I'm

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going to open it for questions and-

MALE SPEAKER 2: [inaudible] in all of these things that put people at risk. Why are we focusing so much on the third element? Is it because we're so much more familiar with and comfortable with alcohol abuse and in the respect put people [inaudible] why is this focus on [inaudible]

MALE SPEAKER 1: Well I think that is a good question.

DR. GORDON MANERGH: I think that is a good question. [Inaudible] Oh the question is why we're focusing on Meth and not other substances? It's the drug devour. You know in some ways. Other substances are like linked to sexual behavior. Meth is something that we've seen an increase wave with in the past ten to fifteen years moving west to east. It's become a community consciousness because of the movement I think and I do want to reiterate that the issue of race ethnicity and age being associated with meth use. This is a moving target. It is moving rapidly. So the data I showed you today from five years ago, from 2000 maybe very different from what it is actually today. So that is why surveillance is such a key to keeping a hold of how this thing is moving along but I think the reason that meth is the big one today is because of the rapid increase but also because of the rapid devastation and that happened at the [inaudible] level that we seen and heard today. So it is not the only substance and I think one of the recommendations that

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primarily will come out of the council in January is that we don't focus exclusively on that. That we focus on all substance used because of the issue of somebody moving to another substance. Just to clarify that the prevalence issue that was from that one city was that meth was the third most prevalently used substance during sexual misbehavior.

DR. BARBARA WARREN: Just to add to that an interesting development in New York State and I really like what Leo said about like not only attacking this from the Federal level but also looking at the state. For years and years the state of those of us who work there have been advocating in our single state agency which is called in your state, the Office of Alcohol and Substance Abuse Services do an LGBT specific substance abuse initiative action plan something. It is really only recently around their fear of Crystal Methamphetamine use and it is morphing from just in the gay community going into straight populations particularly there is some early evidence in New York now that shows that there are a lot of heterosexual identified adolescents in the club scene who are now using Crystal. It is only around that issue that we sort of got wedge in the door to finally fund an LGBT substance abuse initiative at Oasis and this is after at least in my case of like almost 18 years of advocating for that. So you know it is interesting and I think there is sort of like a social political context

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to your question but you know we're using it. If this can open the door to culturally confident substance abuse services for the LGBT community then we're going to use it that way.

MALE SPEAKER 3: Young gay men may be getting in over their head before they realize what the danger really is and that is why I think it is and that's why I think some focus on Crystal Meth and the new risk that are out there. It is important in terms of educating the community. I see part of what we need to do is kind of re-brand Crystal Meth so that's it not consider just another innocent party drug but a much more dangerous drug and to have people recognize it. I think there are casual drug users that would never touch Heroin. I mean if just has a brand name that they are not going to go near and if we just move Crystal across that line so that you know people don't think of it as something you can casually pick up and put down that that maybe part of the solution.

MALE SPEAKER 1: One more comment?

MALE SPEAKER 4: In this publication that says that 45% of [inaudible] were men of color. I just think that when we talk about cultural competent in terms of LGBT issues that the cultural competent we have to take it in consideration to be 45% you know and it is just not but you barely mentioned to and I just think we need to take more into consideration because of competency in terms of language, the immigration

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status you know, all of those kinds of things. I think also when you look at the statistics for HIV it is the men of color. People of color aren't getting it and yet we just don't care about it. We're paying attention to Meth. I know it is important to look at all populations but when you actually look at the ones that are getting the highest prevalence and although people of color always get a second place. We need to actually take a look at the issues of individual racism and why those issues occur.

MALE SPEAKER 1: Any response to that?

DR. GORDON MANSERGH: That's a really good point and CDC I think in the past years has really tried to address that issue a lot more. All the studies that I am involved with we have or we target a third Latino, a third African American in all our studies so that we can access at the racial level certain factors and issues and find out specifically within race issues that are involved and also so we can design interventions that are based on those factors and associated with risk within race ethnicity. Yeah.

MALE SPEAKER 5: [inaudible] health in general and this week all the panelist talked about diverse issues but then you don't present the statistics. With all due respect the difference between communities of color and the information is not given to the colleague or unless people ask about it or bring it up as an issue.

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DR. FORDON MANSERGH: I did present some data on that.

DR. BARBARA WARREN: In fact that 45% figure comes out of studies that have been done in New York recently. In fact what we have been doing with that just at the local level is we have been going around and presenting that data in people of color organizations and last summer we put together a kind of interagency committee and presented all that data and we did some focus groups and we devoted all the funding at the LGBT Center got for our part of the Crystal Meth Prevention Program to target men of color in New York City. So at the local level some of us are trying to respond to that. I think you are right we do need to bare that in mind that LGBT is one level of cultural competency but then we have LGBY targeted to African descent, African Americans, Caribbean and you know you can go on and on. We need to very cognivence of that. Also the other thing we haven't done a good job of so far and I can attest to this because I just did a National Search on this and I literally tore my hair out and I found one campaign. We have done a really bad job of targeted it to you. Particularly young people between ages of like 13 and 18 and actually the Federal Government hasn't done a good job in the ten years that they have been dong Methamphetamine initiative prevention. There is not one prevention campaign, Meth Prevention Campaign targeted to

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gang or straight youth anywhere in this country. There is a new PSA that came out of the Oregon Partnership that Max Margoly Susadol [misspelled?] has shared with me. We are going to do something in New York City but there is nothing proven and nothing targeted to young people gay or straight around the Methamphetamine issue.

MALE SPEAKER 1: Okay in the back, back there.

MALE SPEAKER 6: I wanted to make a comment actually. I'm Joe Nisan, Executive Director of New Leaf Services in San Francisco and we are an outpatient-counseling center for the LGBT community. Antidotally what we see on a day-to-day basis in our substance abuse services and I think it is an issue that tends to get minimized is the impact of heterosexism. We have men of all ages come into our program who are still struggling with a feeling of lost of connection to community. A real isolation, depression and I think it is important to look at these issues in terms of mental health content and social psychological impacts. The underlying depression that feeds addiction, the loss of connection it is crucial both the larger society recognizes the institutional based on heterosexism. We live in a cultural where you know on a weekly basis you can pick up the paper where there is someone in a larger community saying don't say I'm homophobic just because I don't support gay marriage. Don't say I'm homophobic just because this particular institution doesn't

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support gay rights. The reality is that that takes an impact. The other thing is that I think within the LGBT community is that we tend to minimize it also. In that when you're living gay mecha people tend to think how can I still have issues about being gay and the reality is there is this underlying piece. So in dealing with Crystal Meth it is important to look at the mental health psychological components also.

MALE SPEAKER 1: I'm going to take two more then we have to close back there.

FEMALE SPEAKER: Thank you. What's in this piece for women? I have been getting inquiries from the media saying what's happening out there in the LGBT community centers and do you know anything yet are you extracting any data relevant to women? I think this piece is connected to a very profitable [inaudible] when I'm out there traveling community centers across the country there is a whole lot of women that have waited for breast cancer [inaudible] and get some support action that's around that. It would be good to have some information so that women could feel that they are not being put on the back burner again for another issue. So what do we know about women and this issue?

DR. BARBARA WARREN: I'll take a stab at that. Well again there is good news and there is bad news. We have had some women come to the center presenting Crystal

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Methamphetamine use. One of them was Latino identified. More of them are straight identified. Interestingly enough. They are coming to the center because they feel like it is a safe place to come and ask for help given that there is a stigma attached to the use of or being addicted to Methamphetamine and also dealing with being a female. So I'm very happy that it is not a big huge lesbian health problem. It is a much bigger issue among heterosexual woman. On the other side of the coin once again it is challenged to lesbian, bi and trans-identified women in the community that men in the community are now dealing with this issue again. It is an issue that could obscure or dominant the LGBT health scene and I don't really know what the answer to that is. The answer is that again and I always go back and this is me I always go back to and I can use this figure if by now it is a gazillion dollars more. I keep saying we need 7 billion dollars in Iraq, wow that could have plugged a lesbian, gay, bi-sexual, transgender, heterosexual, etc, etc, etc. So I think there is an allocation of resources issue within the community but then there is also a larger issue. There isn't enough money out there to do everything that we want to do. If we can allocate it justly and barely into the right causes so I really can't let this divide if we really need to-. There is enough money we need breast cancer for lesbians. We need all kinds of, we need author of wellness issues for

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lesbians and we need to pay attention to health issues of gay, bi-sexual, and other men who have sex with men.

DR. GORDON MANSERGH: I just want to say briefly that we planed our document around the needs of gay men because that is the issue we wanted to look at. I think that a lot of the recommendations I think we do need to be cognitive to broaden it out. The CDC consultation was around sexual misbehaviors some of the big focus on gay men and MSM but it wasn't limited to that so presumably the report will speak for women as part of these recommendations. I guess there are specific issues around preventions and treatments. I think that is a good point. We'll have you to know you can do specific advocacies. It is important for the communities of specific advocacy on this issue for gay members and I think you are right that we have to be mindful that it is a broader issue and incorporate women and other populations to have discussions when we're broader advocacy on this issue.

MALE SPEAKER 8: Yeah I just want to add quickly that it is going to be a recommendation. We need to know more about other populations besides MSM. It is the population that has brought this to the forefront of our concerns specifically for sexual risk behavior but we do need to explore other populations as well.

MALE SPEAKER 9: Yeah hi, Phil McKesson, The National Association of Gay Professionals. I appreciate these panelist

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for sharing their resources and information with us. I guess as a treatment specialist I am very concerned about the actual treatment aspect of this. That with long-term use there is also long-term withdrawal syndrome, which some people had mentioned but I don't think our community is fully prepared to embrace that and recognizes it. Particularly the toe curling depression that sets in. A lot of people self-medicate using Crystal Meth and yet when they stop using their depression is actually more severe than originated from and I think that we have to be prepared for that. I think the string on the healthcare system, the metabolism changes that occur. The increase in dental needs following post using, I think what we are seeing today I think we have a lot of momentum around prevention but we also have the balance out the matrix that is going to cover treatment also. Without that we're going to see an increase in the return to using. They are all going to see short measurable periods of that. The matrix of treatment is good but we have to move people towards maintaining [inaudible]

MALE SPEAKER 1: [inaudible]

MALE SPEAKER 10: I guess I just wanted to ask any specifically about the long-term depression that seems to occur with this. I guess the concern I do have SSRIs and other medications that have been used. I've also read reports where-

DR. BARBARA WARREN: They are contra indicating.

MALE SPEAKER 10: They're contra-interacting.

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DR. BARBARA WARREN: Yes, yes. People are aware of that and like I'm not a physician and there are probably physicians in this room that can speak to this much better than I. I know that there are some studies that are going on now about pharmacologic interventions particularly for chronic users who are trying to stay clean and sober. And so again the good news is that there are people aware of that and looking into that and the bad news is we need much more resources to that and not just for gay men. I mean there is a twenty to thirty year history of chronic Methamphetamine use on the West Coast that they are grabbing with. The other point that you make Phil is a good one and that relapse prevention. That is a community based thing and that ties into what Joe was talking about and what Jay was talking about. Coming back to a caring community, a supportive community and a community that is going to deal with the kind of heterosexism and homophobic and marginization that drives people to feel that way in the first place.

DR. GORDON MANSERGH: That is going to be one of our recommendations also coming out a comprehensive response all the way across the board from awareness to the other end.

MALE SPEAKER 1: I wanted to in closing thank our panelist and also to thank both the Kaiser Family Network for broadcasting this discussion, which I think, is very important and timely. Also of course the Coalition of Health which working with the Kaiser Foundation made it possible? I think I

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am going to give you Donald who is going to give you some
information about lunch. [Applause]

[END RECORDING]