

Report Back from the MSM IDU Forum

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**Sponsors: Technology and Information Exchange (TIE) Core,
Center for AIDS Prevention Studies (CAPS)
AIDS Policy Research Center (APRC)**

- I. HIV and HIV Risk Among MSM IDUs**
- II. Discussion of MSM IDU Issues and Needs**
- III. Program Suggestions**
- IV. Research Suggestions**

Background

This forum grew out of an interest in having dialogues between researchers, providers and community members (these categories are not mutually exclusive groups). This would serve the dual purpose of giving research legs so that it can inform programs and helping ensure that program and life experience inform research studies.

Another factor for calling this meeting was the high prevalence of HIV among men who have sex with men and are also injection drug users (MSM IDUs). In San Francisco, the prevalence of HIV among MSM IDUs is 35%. MSM IDUs make up 9% of the cumulative AIDS cases in California, and 6% of the cumulative AIDS cases in the US. Currently, the San Francisco Community Planning Group has listed MSM IDUs as a top priority for prevention programs and funding.

Despite the high prevalence rates and interest in serving this population, there are few services, limited infrastructure and scant research specifically addressing MSM IDUs. Most of the funding is divided between MSM-specific and IDU-specific, as well divided between care and prevention, HIV+ and HIV-.

As a result of this first informal meeting, CAPS is providing this Report Back on the forum, and a roster of participants to encourage ongoing discussion and networking among service providers, researchers and others working with MSM IDUs.

NOTE: The ground rules of this meeting were that specific comments were not attributed to specific people. This Report is intended to be a summary of the different views and ideas from the forum; not every point made is included. **This Report is not a consensus.**

I. HIV and HIV Risk Among MSM IDUs

San Francisco DPH

The San Francisco Department of Public Health presented data on MSM IDUs from a 1997 Consensus Meeting and from studies conducted at various agencies serving the

community. Handouts were given at the meeting, so we will only present an overview of the data.

The 1997 Consensus Meeting estimated that in San Francisco, the number of MSM is 43,100, and of those, 4,100 are also IDUs. The HIV prevalence for MSM IDUs is 35%, incidence 2.0%. In general, prevalence increased in 1994-95 and has tapered off since then.

It was noted that these numbers were decided at the consensus by researchers submitting their estimates and the reasons behind them, and the final numbers were reached by consensus. Also noted that there was not a lot of disagreement between the members of the consensus. The numbers decided on were then applied to general population racial and age breakdowns to further analyze the data.

Several studies conducted at STD clinics, methadone treatment centers and drug detoxification programs showed general declines in HIV prevalence among MSM IDUs. The one exception was among youth entering homeless centers, where there continued to be a high percentage of HIV+ MSM IDU youth. This may be because many youth known to be HIV+ are referred there.

There was a question as to whether this decline in prevalence has to do with treatment or risk behavior. The decline might also be attributed to client migration out of clinics, as a large proportion of HIV+ MSM IDUs might be seen elsewhere. Also, the decline might be due to the fact that people get sick and die or get sick and move out of San Francisco.

Urban Health Study

The Urban Health Study (UHS) at UCSF also presented data on MSM IDUs. Since 1986, UHS has gone into three neighborhoods every six months to test IDUs for HIV. In 1996 they added Bayview Hunters Point neighborhood. The data presented is from link clients who have come more than once to the study.

Between 1986 and 1998, 70 people seroconverted. Compared to those who did not seroconvert, the biggest risk factor was being MSM. Risks were also very neighborhood specific: the odds ratio of HIV infection among MSM in the Tenderloin was 12. The largest risk category was among men. Women's main risk factor was sex work. Sex work not a factor for MSM, but many did exchange sex for drugs or money.

Among IDUs, sexual risk seems to be driving the HIV epidemic more than needle sharing. In SF there have been myriad interventions for IDUs, perhaps explaining the decreased injection-related risk.

UHS also mentioned that their recruitment methods are good at reaching IDUs but not MSM IDUs. The following data is reported from the 44 (out of 750) MSM IDUS that were interviewed in summer 1999.

II. Discussion of MSM IDU Issues and Needs

After presentation and discussion of HIV and HIV risk among MSM IDUs, we had a discussion of MSM IDU issues and needs. The discussion was structured by talking first about how gay men start to inject, what life is like for MSM IDUs, and finally, how men "exit" or stop using drugs, if they do. The goal of this discussion was ultimately to identify program and research needs.

Drug of choice

There are many drugs of choice for MSM IDUs. There was a lot of talk about speed, and there are some programs to address it (Stonewall). In the East Bay, they're still seeing a lot of heroin use. Is there a class, race or geographic difference between MSM who use heroin and speed? For many MSM/IDUs, self identity is more closely aligned with drug of choice than with sexual behavior or drug using behavior. The kind of drug chosen also affects drug use, sexual activity, etc.

Drug use habits

There is a wide variety of drug use patterns among MSM IDUs. Some have only occasional and very planned drug use, i.e. planning for an out-of-town circuit party that is attended once a year, or during special events in the Bay Area (pride weekend, Folsom St. Fair). This group may plan for a long weekend "binge" from Friday through Monday, and then head back to work on Tuesday. They may be highly functional and not self-identify as IDUs. Others may be regular shooters but be self-regulated, holding down jobs and homes and not seeing drug use as a problem. The most visible group is perhaps the addict who may be out of control of his drug use, living on the streets or marginally housed and in greater need of services. There is also a great deal of fluidity between these categories, with people passing between them during their drug use history (see Path through IDU).

Risk factors - sex v. drug use

For speed users, drug use seems to be linked to increased sexual activity, or hyper-sexuality. Drug use may be planned around certain events where sex is expected to occur (circuit parties, raves, party weekends). However, in many cases it's hard to tease out whether the risk is with sex or injection practices. Both sharing needles and having multiple partners are occurring, lasting several days. Men may start their drug use very clear on what they're doing, and don't share needles. By the end of the weekend, needles get mixed up, and they're not sure whose is whose.

A few years back there was some data on the difference in sexual activity between heterosexuals and homosexuals using speed with or without IDU. MSM's gay sexual behavior with speed use was highly sexualized compared to hetero people. Other folks

(not MSM IDUs) are having a lot of sex but not getting infected. If it's the sex that is the risk factor, maybe MSMS IDUs are having more sex or more high-risk sex. Childhood rape or sexual molestation might be a better explanation—there's a lot going on.

Heroin use is less linked to sexual activity. There is a belief that heroin users are not having as much or as risky sex.

Self-Identity- MSM v. IDU

There were a lot of questions whether MSM IDUs self-identify as such, in several ways: whether the MSM identity is stronger than the IDU identity (or vice versa), whether MSMs self identify as gay or heterosexual, and whether men who inject identify themselves as IDUs or not. There is stigma within the MSM community for men who shoot drugs, as well as stigma within the IDU community for homosexuals.

For some men, MSM activity is situational (while in prison/jail, selling sex for money/drugs) and they do not identify as gay. These men may be at greatest risk for HIV; in one study of MSM IDUs in New York, Los Angeles, Chicago and San Francisco, heterosexual identity was a risk factor for ever injecting.

Likewise, for some men IDU activity is situational (circuit parties, etc.) and they do not identify as IDUs. For these men, shooting speed is a normal part of these activities, just like drinking beer is a normal part of watching a sporting event. There is a lot of fluidity around injecting and speed, with certain men being regular injectors, some never injecting, and a middle ground of people who inject once in a while.

Path into IDU

How do men initiate drug use and injection drug use? For some MSM, speed use may be part of the coming out process, either as an "initiation rite" or to deal with being gay. It may also be a part of general experimentation during youth, the excitement of taking risks and trying new things. It may start with an HIV diagnosis or the death of a lover, to deal (or not deal) with disease. Some older gay men start shooting speed when they move into San Francisco: speed may be seen as a "local specialty."

At the SFGH emergency room, they're seeing an increase in speed users who use needles, who would not have used needles in the past. Some men start by snorting speed and then end up shooting. It may have started with crack—many men on Polk Street who used to snort crack are now shooting speed.

Initiation may also start as a way of dealing with mental health issues such as childhood abuse, internalized homophobia, low self-esteem, etc. Also, we do not treat gay youth very well in this country. There is little support or services and some gay youth are deeply wounded, go untreated, move into the underclass of living on the street, trading sex for speed, and end up HIV infected.

Path through IDU

The journey through drug use is often a spiral, with relapses and movement in and out of drug use, drug of choice and means of taking in the drug. For some men, as they get into recovery, they get into snorting. But economically snorting is not as feasible and after a while they get back to shooting. This is true with heroin and with speed.

Relapses occur frequently in drug treatment, as does changing drug of choice. At housing facilities, those in recovery who have been IDUs and have relapse are using other drugs, whether smoking it snorting it or shooting. Relapses often happen not necessarily with speed, but with new drugs.

A study in LA showed that among MSM IDUs there were two distinct groups. The first group was upper to middle class, mostly white, shot up inside their homes, went to bars to pick up men and maintained "a facade of being respectable people." The second group lived 5 to 6 in apartment or lived on the street and engaged in survival street sex. Interestingly, in the study, people in group one became the people in group two over time.

Path out of IDU

One of the largest group of former IDUs may be men who simply age out of IDU or get into recovery all by themselves. We tend to concentrate on the men we see, i.e. men in drug treatment or recovery programs. Also, there are some men who never seek a path "out" of drug use, who see their drug use as a manageable. Some motivators for stopping drug use may be "having something to live for" such as children. Not a lot is known about how people leave drug use.

Mental health issues

Most MSM IDUs have significant mental health issues. The amount of shame involved in both MSM and IDU activity can't be overestimated. At the clinic at SFGH, they're seeing a lot of triple diagnosed clients (HIV, substance use and mental health issues such as personality disorders, narcissistic and borderline personalities.) Data from the CAPS Gay Urban Men's Study (GUMS) show that risk factors for MSM IDUs include childhood sexual abuse, relationship violence, mental attitudes and alienation. At the PLUS program, out of 30 newly infected men, half said they used speed, and of those, half said they inject. When asked how many men feel that issues around self-esteem and self identity had to do with their seroconversion, a large majority raised their hands. At Stonewall, although they bill themselves as being an integrated substance abuse, mental health and HIV program, a lot of staff don't have the training in all those areas. In talking about mental health issues, it's important to note that to think people will be willing to deal with childhood trauma right off the bat is a little facile. Mental health services need to be offered on an ongoing basis.

SES factors

There seems to be some correlation between economic level, class, geography and other social issues and drug use and /or HIV infection. There was not much known about whether SES factors are predictors of drug of choice, drug use or sexual behaviors. It seems as though programs in San Francisco are not great at getting men from all different walks of life. It was also acknowledged that in talking about class, we weren't just talking about targeting "poor folks" but rich ones as well. We can't let the well off, "top tier" in the Castro off the hook, because they're also shooting speed and getting HIV infected.

Community norms in gay community

In San Francisco, levels of speed use are much higher than other places in country. Emergency room statistics show that San Francisco used to be #1 in the US in admissions for heroin overdose. Now San Francisco is #1 in the US for speed overdoses. Why would residence in San Francisco be predictive of increased speed use? There have to be factors around norms in subcommunities that support speed use.

For many gay young men who just got out of school, just moved to San Francisco, there is a sense of independence and freedom. They look around to see what is normal and what they see is partying! Newspapers, stores, advertisements, flyers are all about partying. No one tells them what's normal, what's expected of the gay community. And there are no services for that group.

In the city there is some resistance to putting educational messages at club venues, rave sectors and circuit parties. The Drug Rave Task Force has been successful in beginning working in these areas, but there is still a sense of "leave us alone." Where does the responsibility lay?

Harm reduction v. abstinence

Many men are highly wary of programs that seem to be telling them to stop drug use or sexual activity. The goal is to reduce HIV transmission. For some men, drug use may not be equivalent to addiction. Currently, abstinence is the accepted model for drug abuse treatment. Many agencies require clients to be clean and sober before offering services.

Hepatitis C was cited as a particular problem that is incredibly unforgiving of slips. Since HCV is so easily transmitted via sharing injection equipment, it may require more of an abstinence model. With HIV, reducing risk behavior by 80% can achieve wonderful results but that may not be enough for HCV. We may have to eliminate risks by 95-100% to stop HCV transmission.

Gay-friendly drug treatment

There is a big discrepancy between MSM IDU and IDU services, and traditionally the two haven't mixed. It is thought that few gay men access IDU services such as needle exchange or drug treatment. IDU-specific services may be directly or indirectly homophobic. In Santa Cruz, the problem for HIV+ gay male IDUs is that drug treatment

is not culturally competent. The treatment center is run by heterosexuals and doesn't address gay men's drug use or sexual behavior issues. In San Francisco there is only one gay-run treatment facility, and we need a lot more.

Viagra

The drug Viagra has played a big role in the sex lives of some MSM/IDUs and possibly in increasing high-risk sexual activity. As one discussant said, speed users can now get hard-ons. In a study of gay men attending circuit parties, use of Viagra was the highest predictor of risk behavior.

III. Program Suggestions

From our discussion of MSM IDU issues and needs, five program suggestions evolved: MSM IDU-specific needle exchange, integration of services, focus on harm reduction, increase provider sensitivity to MSM IDUs, and challenging community norms and community education.

New Models for Needle Exchange Programs

The women-only and youth-only needle exchange programs (NEPs) in San Francisco have been very popular. Why not an exchange for MSMs only? Make it a safe place to go, give referrals to other services and have a counselor available. There could also be a transgender-only NEP, and each NEP will need different services.

Gay guys on speed may not come to street-based NEP. In Sacramento, where there are more speed users than heroin users, they have a pager delivery service. Could also use a van for outreach and an internet site.

The Seattle NEP started Neon, a 'zine for MSM IDUs filled with sophisticated information about safe shooting and personal health. They also have services for people who want to stop shooting, as well as for those who don't want to stop.

We do needle exchange in San Francisco very tentatively. Perhaps we could use a marketing campaign to let MSM know we do NEP for them too.

There are many hidden populations of MSM IDUs who inject at home and don't come out into street, and most of our outreach is missing them. NEPs might offer services at non-traditional times. Also, NEP should target secondary exchangers for prevention messages, perhaps by training secondary exchangers to deliver prevention messages to friends at home.

Integration/Collaboration between agencies

San Francisco needs a "one-stop shopping" MSM IDU clinic that addresses drug use, mental issues, youth issues, HIV prevention, etc. If someone is on drugs, they don't want to go around looking for services. One suggestion was a place with "3 hots and a cot" and primary medical care for detoxing. The primary care model might be another approach, like the Health Center #1 for lesbian, gay, transgenders and youth. Such a clinic could give access to men who have insurance but won't go to their doctor at Kaiser and say "I've been shooting speed, doc." Someone mentioned an agency in the Tenderloin that has a space where all the services can be accessed and clients go there regardless of age, race, etc.

Another important factor for collaboration is cross-training for folks who work at diverse agencies to improve quality and expand delivery of their services. Conduct AIDS 101 classes at substance abuse agencies. Train mental health agencies in drug use and HIV, especially surrounding interaction of HIV meds, different street drugs and anti-depression meds. Offer support groups at HIV agencies focusing on early recovery and the drug-sex connection. Make sure to target these efforts to HIV+ as well as HIV- MSM IDUs.

We also need to link with STD prevention and especially HCV prevention. One way to access a lot of men who wouldn't come to an HIV prevention or substance use program is to link with STD clinics.

We need a resource inventory that lists all agencies that are seeing MSM IDUs, including their funding and interventions and target population, to give a sense of what programs are out there and who they serve. Networking is key, using peer networks, outreach workers, forums (like this one) for service providers and researchers, etc. Each of us working in this field needs to keep both issues on the table—MSM and IDU—whether working in a primarily IDU-oriented agency or MSM-oriented.

Harm reduction, not abstinence

The abstinence-based recovery model is not the only way to go. We need to work with existing agencies to lessen abstinence requirements for services. HIV+ men should have access to any service even if still shooting drugs. We need to be clear about the goal being HIV prevention, not abstinence of sex or drugs. With a harm reduction approach, perhaps we can catch people earlier in their stage of drug use and intervene before drug use becomes harmful.

Stonewall services are centered around speed use and it's not necessary to be clean and sober to attend. By focusing on speed, the one thing that all their clients have in common, they have been successful at reaching a wide variety of men.

Safe places and sensitivity

What do MSM IDUs want? One survey found that youth suggested opening a safe place to meet, like a cyber cafe on Polk St. This would be a place to get coffee, get online, and get HIV/STD testing, plus a full range of services in a room in the back. The primary

reason for coming to this place would be to use computers. Volunteers can also be on-line to offer advice or education.

While it's true that there need to be better integrated services that address multiple issues, many times the response and success rates have to do with the level of caring and compassion of the service providers. Drug users have informal networks, and often know where NOT to go because they won't be treated with respect. Service providers might benefit from training to better understand the needs and issues of MSM IDUs. To help feel comfortable at an agency, MSM IDUs want friendly, caring providers who know their needs and concerns and aren't stigmatizing.

Education on speed use

A lot of MSM IDUs are hungry for information on how to take care of themselves. STOP AIDS offered workshops for gay male drug users. One series was specifically for guys on speed. One day they talked about sex and speed, pharmacology and speed. People are looking for very specific information about speed, like safe shooting, drinking lots of orange juice for hydration, practical and specific information speed users don't get. For example, instead of saying eat a high protein diet, explain that it means eating a lot of chicken and tofu. If we address MSM IDUs' broad health concerns, HIV will come up naturally.

Changing community norms

We need more strategies for changing community norms. There are interventions that have been proven successful including using popular opinion leaders or harm reduction messages. Individual-level education and drug treatment doesn't have sustained results. At one detox clinic, they had short-term efficacy with some clients who do have sustained recovery. But a study of clients a year after leaving the clinic found that of the clients who successfully detoxed, half could not be found. Of those half that were found, one quarter reported relapsed since being at clinic. Maybe the whole community needs to change, to help the gay community help its brothers.

Agencies are just one part of the solution. We need to disseminate the healing as much as possible throughout the community, starting with journalists. Encourage journalists to be aware of speed use and its impact in the gay community. Ask writer friends to write an article about what you can do if a friend is a speed user. Agencies are not the sole owners of revolution within the community. Encourage writers, playwrights and authors to write about speed like we've written about HIV.

IV. Research and Policy Questions

Life as an MSM IDU

We don't know enough about the day-to-day lives of MSM IDUs. What are some of the most common trajectories in and out of injection? Are there multiple trajectories that could be predicted? Learning about the paths taken can show where the windows of opportunity are for intervention. What do MSM IDUs do to stop drug use, be it treatment, 12-step, intervention from friends? What about MSM IDUs who stop injecting on their own, without treatment? How do continuing users maintain safe injecting and safe sex practices? Are there lessons to be learned from their success stories? What are the differences in epidemiology and risk behavior between men who inject speed and men who inject heroin? How can these differences be used to target programs?

Policy making and funding

MSM IDUs seem to continually get left out when it comes to funding and programs. Although there is a 35% prevalence, they only receive 6% of total prevention funding in San Francisco. We need research to follow money for this population. What facilitators and barriers are there for Community Planning Groups (CPGs) to intervene on behalf of MSM IDU populations? This report can be fed to CPGs across the county to show some ideas and key issues. We can also work with CPGs to look at funding opportunities for integrated services.

At the agency level, it's difficult to get funding to do integrated care service. CPG doesn't want to fund mental health programs, Ryan White doesn't want to fund prevention. There is also a problem getting funding because of the perceived notion that we are "pathologizing gay men." We need to continue to talk about and advocate for the importance of mental health and integrated care, and educate funders on the needs of this population.

Harm reduction

Harm reduction is a controversial topic in substance abuse research and treatment. There is a lot of distrust of this approach in a world that has been traditionally abstinence-based. Research that demonstrates the efficacy of harm reduction would help in legitimizing this approach. Also, it is extremely frustrating to try to get funded for harm reduction programs—you can't even use that word with federal funders.

Collaboration issues

We need studies of institutional resistance to interagency collaboration. What are facilitators and barriers to collaboration? What are some models that can be replicated? Also, we need clinical research on interaction between different drugs. We have some information on street drugs and HIV medications. What about street drugs and antidepressants? Men with drug problems are now referred to psychiatrists, and the sense is that doctors are winging it. For example, we don't know if men should be clean and sober for 6 months, 1 month or not at all before prescribing antidepressants.

Treatment issues

We need research on different treatment modalities for speed users. MSM IDUs could also use a beacon warning system that lets people know what's changing in drug culture. It could inform people what particular kinds of drugs are on the streets this weekend and how to use them safely.

Treatment for a variety of factors needs to be available for all MSM IDUs, no matter what their stage of drug use. Men who are currently injecting should have access to HIV treatment, STD and hepatitis treatment, as well as mental health and recovery services.

Recruitment

There is a need to recruit more MSM IDUs into studies looking at drug users or gay men. In addition, we need studies that specifically address the needs of MSM IDUs.