



The STEP Ezine



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The Seattle Treatment Education Project's (STEP) EZINE is an electronic treatment resource newsletter distributed monthly to case managers, front-line workers, people affected by HIV/AIDS, physicians, other public health and allied health professionals and people living with HIV/AIDS.

STEP's contact information is: STEP at Lifelong AIDS Alliance, 1002 E. Seneca Street, Seattle, WA 98122 (206) 329-4857 o (206) 957-1659. We also have a toll free number 1-888-399- (STEP) 7837 Anywhere in the US

Harm Reduction for Methamphetamine Users

Part Two

by Susan Kingston

Current literature provides ample information linking methamphetamine use with HIV transmission, particularly among men who have sex with men and injection drug users. Studies have documented alarming rates of unprotected sex, increased numbers of sexual partners, and high prevalence of HIV and other sexually transmitted diseases among methamphetamine users.¹⁻⁴ Harm reduction counseling can fill a critical gap in addressing the health needs of users who may not be reached by other responses such as drug treatment or substance use prevention.

Characteristics of Methamphetamine

The pharmacology, behavioral norms, and neurological impact of methamphetamine use present unique challenges to harm reduction approaches. A typical methamphetamine high lasts 8 to 12 hours (a cocaine high lasts only 15 to 30 minutes) and often stretches into a longer "run" during which a user maintains a high, usually without sleep, for days or even weeks. Several days of exhaustion, sleep, and acute depression, known as the "crash," follow the high. During these extended ups and downs, methamphetamine users may be too distracted, exhausted, or secluded to engage in clinical interventions.

Additionally, the paranoia or psychosis that can result from chronic use or sleep deprivation often keeps users away from services such as needle exchange, drug treatment, and health clinics, all traditional engagement points for users of other drugs. Cognitive impairment as a result of chronic drug use, concurrent mood or hyperactivity disorders, and compulsive sexual behavior are typical and add to the complexity of counseling methamphetamine users. While the philosophy and objective of harm reduction—the support of positive, incremental change towards client-defined goals—do not differ depending on the drug of choice, the implementation of harm reduction does. Applying the harm reduction mantra “meeting users where they are at” can be difficult with methamphetamine users, whose exact “at” points are either hidden beneath layers of distrust or are constantly shifting in waves of drug-induced impulsivity. This article discusses how service delivery and counseling might be structured to further harm reduction goals for people who use methamphetamine.

Methamphetamine use impairs attention span, memory acuity, impulse control, learning function, and abstract thinking. This diminishes users' abilities to process or recall information and to conduct abstract cognitive functions such as perceiving risk and consequences, making decisions, and prioritizing actions. To accommodate these deficits and enhance client engagement and retention, implementing service elements such as telephone reminders, flexible “no-show” policies, and access to multiple services in one visit or location can be useful.

Mornings, Mondays, and Fridays (when users are often high or crashing) tend to be poor times for service utilization. Evenings and mid-week days work better. Drop-in hours rather than strict appointment schedules, very brief (or no) intake forms, and shortened waiting times better serve these clients, who tend to react spontaneously to their own needs and have diminished tolerance for stress and frustration.

Addressing Harms of Methamphetamine

Given the nature of methamphetamine use, there are three key harms that might be minimized through counseling. To compensate for client impulsivity and impaired judgment, counselors should help clients develop personalized plans to avoid harm and maintain safety *before* getting high.

The most basic harm reduction message for users addresses essential human needs: eat, drink water, and sleep. Meeting these needs will help the body withstand highs, ease crashes, and delay the onset of paranoia—all effective “selling points” for users.

Sexual activity is a second focal point. Methamphetamine can be a powerful sexual stimulant for both men and women, resulting in longer-lasting, more frequent, and more compulsive sex than that observed among other drug users. Sexual activity may also diverge from core sexual identity, for example, allowing straight-identified men to

have sex with other men. Not all users, however, are conflicted by this behavior-identity discordance, claiming rather that “On meth, I’m just sexual.” Counselors should avoid interpreting this behavior as orientation confusion; instead, they should assist clients reducing undesirable consequences such as HIV and sexually transmitted disease transmission, pregnancy, or involvement with abusive partners. Again, counselors should encourage clients to think through sexual decisions and make sexual safety plans *before* getting high.

Lastly, commonly shared beliefs among users can contribute to risk taking and harm. Many methamphetamine users consider their drug to be more “functional” than heroin or cocaine. Methamphetamine users see themselves as “getting things done,” including purposeful activities such as sex, work, or home maintenance. They see heroin or cocaine users as spending their highs nodding off or looking for more drugs. This belief in methamphetamine’s “benefit” can nurture feelings of invulnerability to negative consequences. In addition, methamphetamine users see the drug as representing excitement, personal power, escape from restrictive norms, and a desirable risk.

These beliefs may interfere with perception and appreciation of harm. At the same time, however, they offer harm reduction providers effective “leverage points.” Counselors may encourage clients to make positive behavior changes in order to sustain their “high” activities. For example, a male client may cut down on escalating drug use if he is concerned that drug-induced impotence will interfere with desirable sexual activity. Sensation seeking clients may be more open to discussing “harmful” behaviors if counseling affirms this aspect of their personality **and** allows them to define “risk” or negative consequences for themselves.

Dealing with Paranoia

Perhaps the greatest challenge when providing services to methamphetamine users is overcoming distrust and paranoia. Providers may experience difficulty in developing rapport with clients. Understanding methamphetamine vocabulary or use practices and showing patience with impulsive, unfocused, and suspicious behaviors can help demonstrate provider knowledge and acceptance.

Trying to convince clients what is real and what is not is rarely successful and almost always frustrating. Instead, counselors should help clients recognize their own patterns of paranoia and identify ways to reduce anxiety and possible harmful outcomes of paranoid behavior such as arrest, violence or self-injury. An effective counseling probe may be, “I don’t see the people following you, so tell me when they appear and leave. How does it change when you are high or crashing? What helps you feel safer?” This approach validates clients' emotional experiences without necessarily “buying into” their delusions.

Counselors can also structure counseling settings to minimize paranoia, for example, by facing clients away from doors or windows, closing window curtains, dimming bright lights, and avoiding sitting behind desks. Some clients may be suspicious of note taking or other clinical documentation. Ask clients at the outset if they feel comfortable and make appropriate accommodations.

Conclusion

As the epidemic of methamphetamine use continues, counselors are likely to encounter more clients who are using. Despite the challenges of working with these clients, there **is** opportunity for behavior change success, particularly when harm reduction approaches are tailored to meet the unique needs of clients.

References

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Author

Susan Kingston is an Educator Consultant with the Drug Use and HIV Prevention Team at Public Health–Seattle and King County. She specializes in prevention strategies for substance-using men who have sex with men.

All About ACAP

Why ACAP?

The following could be some of the questions that people living with HIV/AIDS in King County may ask themselves:

“I just found out that I have HIV. I’m scared. Where do I go first??”

“I have been positive for 12 years and I haven’t been to the dentist in a long time. Where can I go? Is there payment assistance?”

Navigating the healthcare system is hard enough, but what if you have HIV/AIDS as well? Knowing all the options and details about the many HIV/AIDS doctors and dentists in King County is the first step in starting and maintaining care services. ACAP can assist persons living with HIV/AIDS (PLWH/A) choose the best doctor or dentist for them. ACAP can even make the appointment! Since we are all different and have diverse needs it’s important to start HIV care on the right foot.

The AIDS/HIV Care Access Project (ACAP) is a program of the Washington Health Foundation. Since its inception in 1991, ACAP has been the designated resource for referrals to medical and dental care for PLWH/A in King County. In addition to referring PLWH/A to experienced medical and dental care, ACAP also connects clients to community resources and healthcare coverage options, such as private insurance or state funded programs. ACAP’s goal is to help clients access the HIV/AIDS care system and encourage early intervention.

If we can be of assistance please call 206-284-9277 or 1-800-577-4023.

News flash!

The FDA grants priority review to a co-formulation of Viread (tenofovir) and Emtriva (emtricitabine).

Gilead Sciences the maker of Viread and Emtriva announced that the U.S. Food and Drug Administration (FDA) has granted priority review status to a new *fixed dose* co-formulation of the company’s anti-HIV medications Viread and Emtriva.

Under this status, the New Drug Application (NDA) will review the new co-formulation and make a decision by September 12th, 2004. The proposed co-formulation will contain 300 mg of tenofovir (Viread) and 200 mg of emtricitabine (Emtriva). This new medication if it gets approved, will have to be taken in combination with at least *one* other anti-retroviral.

For more information on this news go to: www.Gilead.com

The Lifelong’s STEP Program Invites You To A Community Meeting

*STEP, a Program of Lifelong
AIDS Alliance, presents:*

“New Issues in HIV Care in 2004”

*Topics like: Resistance, Lipodystrophy, New Medications
HIV “Superinfection”, Quality of Life Issues plus
Information from the World AIDS Conference, the
Retrovirus (CROI) and other recent HIV conferences.*

Scheduled speaker:

David Spach, MD
Professor of Medicine
Division of Infectious Diseases
University of Washington, Seattle

Where: Lifelong AIDS Alliance
Conference Room

Date: August 4, 2004

6:00 to 8:00 pm

Dinner will be provided

Please RSVP at 206-957-1659

Space is limited

Outside Seattle: 1-888-399-7837

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on their Web site link to *thebody.com*?**

Curious?

Visit us online at www.thebody.com/step/steppage.html

ACKNOWLEDGEMENTS

- Please note that this is not a complete list of all HIV-related treatment information. STEP strives to provide the very latest in HIV/AIDS treatment information, research and drug development information. The most current research directions and antiretroviral drug data are provided throughout the Ezine publications. You will find highlight reports as well as extensive follow-up reports from many of the AIDS research and science conferences on the Ezine. In addition, all STEP quarterly treatment journals are available on our Web site at <http://www.thebody.com/step/steppage.html> or by calling our National Talkline at 1-888-399-STEP (7837). STEP works hard to give unbiased treatment information to all interested parties. If you have comments, questions, suggestions or grievances, please contact step@lifelongaidsalliance.org.

The Ezine producer is Roberto Gonzalez

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