



THE CRYSTAL METHAMPHETAMINE PROJECT

Understanding the need for culturally-safe supports and services addressing crystal methamphetamine use among gay, bi, and queer men (both cis and trans).

About this report

This report provides an initial overview of results from the Crystal Methamphetamine Project. The aim of this project was to examine the experiences of sexual and gender diverse men, including trans-men and non-binary people related to crystal methamphetamine and related services and supports. The report is organized into five sections addressing **(1)** patterns of and motives for crystal methamphetamine use, **(2)** gaps in services and supports, **(3)** healthcare and harm reduction preferences, **(4)** the role of trauma and stigma, and **(5)** recommendations for addressing crystal methamphetamine use.

About the Crystal Meth Project

In 2018, we interviewed 33 participants across British Columbia about their experiences using crystal methamphetamine. Based on those interviews, a national online survey was developed for sexual and gender diverse men, including trans-men and non-binary people, who used crystal methamphetamine. Survey participants (n = 780) were recruited primarily using social media advertisements on Squirt and Scruff, as well as the social media accounts of community-based organizations. Survey eligibility criteria restricted participation to self-identified men or non-binary participants, who had had sex with a man in the previous six months, aged 16+, who lived in Canada, and reported crystal methamphetamine use in the past six months.

Most survey participants resided in British Columbia (36%) or Ontario (37%). The majority (78%) identified as gay, 16% as bisexual, 8% as queer or pansexual, and 3% as straight or heteroflexible. In terms of HIV status, 37% participants noted that they were living with HIV, 59% were HIV-negative, and 4% of participants had never been tested. This sample was 72% white, 5% identified as Indigenous, and the remaining 23% identified as other people of colour (5% as African, Caribbean or Black; 4% as Arab or West Asian; 5% as East or Southeast Asian; 3% as South Asian; 5% as Latin American or Hispanic; and 2% as another ethnicity). For some survey analyses, participants were classified into two groups based on the frequency of their meth use in the past six months: 55% were considered frequent users (weekly or more), 45% were considered infrequent users (monthly or less). Pseudonyms were created for all interview participants to provide anonymity.

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PART 1

Patterns and Motives to Use Drugs

Gay, bisexual, queer, and other men who have sex with men (gbMSM) are reportedly ten to twenty times more likely to use crystal methamphetamine compared with the general population.^(1, 2) Party n' Play (PnP), or chemsex, is a key driver of methamphetamine use among gbMSM.⁽³⁾ This is due to methamphetamine's ability to enhance sexual experience and reduce inhibitions.⁽⁴⁾ This section provides an overview of (1) why participants use crystal methamphetamine, (2) whether they wanted to make changes to their methamphetamine use, and (3) how they used crystal methamphetamine.

Why do participants use crystal methamphetamine?

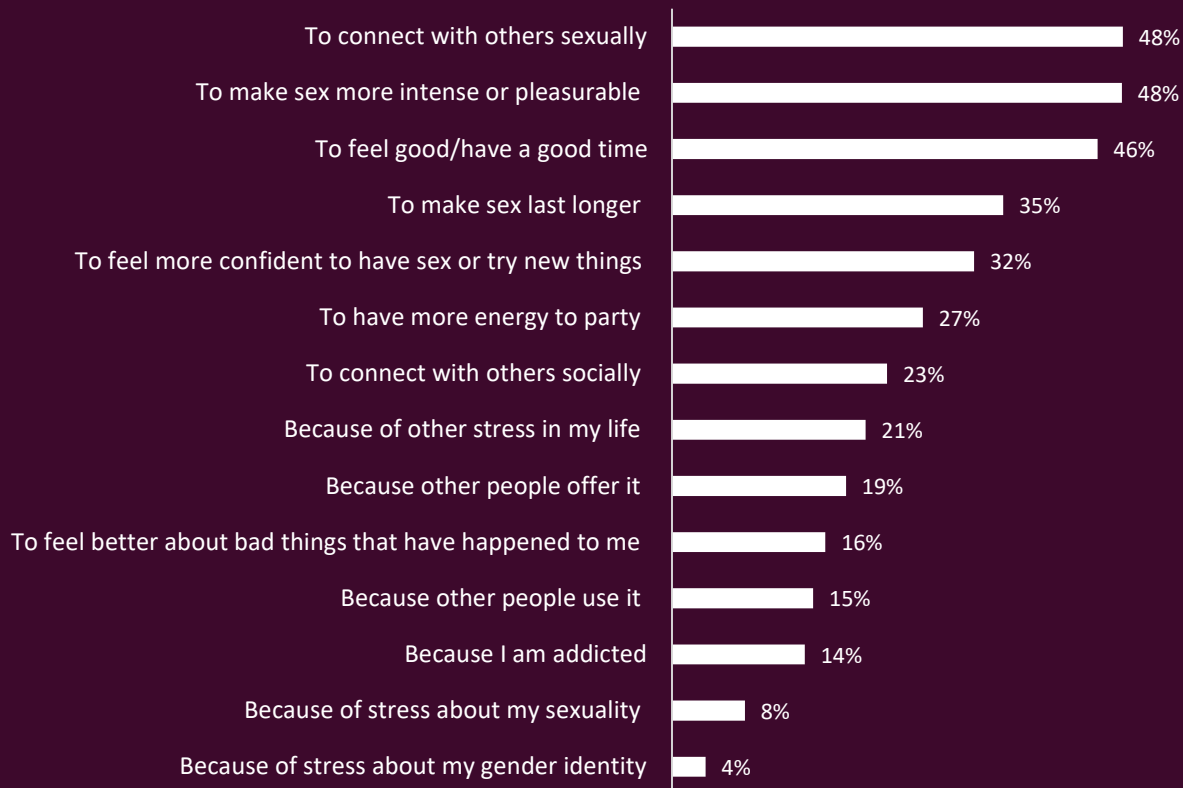
Equally as important to how participants use meth is why they use it. **Figure 2** shows the reasons for using crystal methamphetamine that participants reported. Three broad reasons were for pleasure, to socialize, and to cope.

Enjoyment and Pleasure

Figure 2 demonstrates that motivations for using meth most commonly reported were related to sex, such as to connect with others sexually (48%) and to make sex more pleasurable (48%). Half of respondents indicated that their meth use occurs in the context of sex nearly all of the time. People who used meth more frequently also used it during sex more often.

"If I do crystal, I probably would want to have sex, which is not a bad thing, right, because it is not like I am like a drug addict, I just like to smoke crystal every now and again, you know what I mean. When I do, it is basically because I want to have sex probably, in the back of my head, I wanna have sex and I know [meth] would be like a catalyst to get me going?" (Brian, 50s, HIV-)

Figure 2. Reasons reported for using methamphetamine.



Social Belonging

Survey participants also indicated that they used meth to connect with others socially. As noted in **Figure 2**, a quarter (23%) of participants agreed that social connectedness was a reason for using meth. In addition, a common theme among interview participants was that they felt that being part of the PnP community had led to deeper connections and lasting friendships. Many guys said they enjoyed the social dynamic of the PnP scene, as it provided a “level of respect at the time of intimacy” with friends for guys who weren’t interested in having a “lover or a boyfriend” (Philip, 50s, HIV+). As another respondent noted:

“When I stand back is it about the sex? I don’t think so. I do think it’s about being included because the gay scene is a really tough place to survive I think...So I think it’s to be included. To feel wanted. To be touched. I think there’s some very human pieces of it but it gets distorted really, really quickly on the party drugs.” (James, 60s, HIV+)

While apps and websites were popular ways for guys to find partners, it was also common for participants to find partners through their existing social/sexual circles. One interview participant explained how his circle of PnP partners expanded by meeting people through his existing partners:

“Once you kinda form a group of friends, that you play with you know, or you enjoy their time and you trust them to be at your house for a couple of days or whatnot... So, I mean, it is kinda evolving so to speak.” (Dom, 30s, HIV-)

Sex is an important part of socializing and community for many gbMSM, and sexuality is one of the ways, through identity and practice, that social circles and relationships are formed.⁽⁵⁾ Patterns of substance use among gbMSM are also shaped by the presence of sex and sexuality in community and social spaces, with many gay, bi, and queer men choosing to use meth in sexual and social contexts due to its positive effects on pleasure, intimacy, and social connectedness.⁽⁵⁾

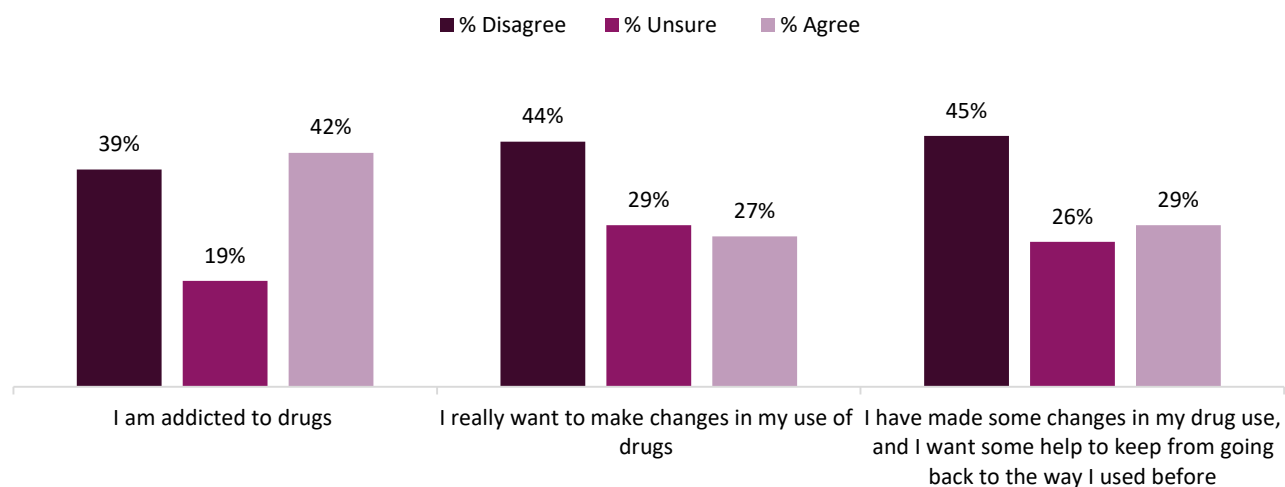
Coping

Current or past life stressors were reported reasons for meth use for approximately 1 of 5 participants. Very few participants reported that their meth use was related to negative feelings towards their sexuality. Among those who reported trans experience, 14% indicated that they were motivated to use meth because of stress due to their gender identity. Others noted that meth helped them escape painful feelings.

Do participants want to reduce or quit using drugs?

Given the many reasons reported for using crystal meth, it’s not surprising that some participants were interested in reducing their drug use or quitting while others were not. **Figure 3** shows attitudes toward participants’ current drug use were mixed, and a significant proportion of respondents were unsure about whether or not they felt addicted, wanted to make changes, or if they had already made changes to their drug use. Frequency of drug use shaped participants’ self-perception of their drug use patterns. For example, a majority (59%) of guys who used meth frequently identified that they were addicted to drugs, while the same proportion (58%) of infrequent users indicated that they disagreed that they were addicted.

Figure 3. Attitudes Toward Current Drug Use

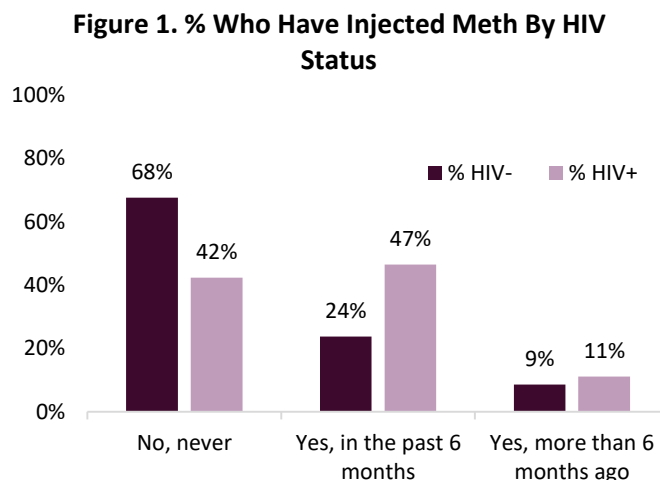


Understanding participants’ motivations for using MA and their attitudes toward their current drug use is crucial for shaping programs and services that will best meet their needs and personal goals.

How do participants use crystal methamphetamine?

"I'd smoke it for a while and then after a while I tried injecting it. And I do both now. When you inject it just seems to come on stronger right away." (Matthew, 30s, HIV-)

About half (55%) of respondents used crystal methamphetamine at least weekly in the past six months. The remaining 45% used crystal methamphetamine only a few times a month or less frequently. Among all participants, 58% had never injected crystal and 32% had injected meth in the past six months. Injecting crystal methamphetamine is sometimes referred to as "slamming" and is common in the PnP scene. **Figure 1** shows elevated prevalence of injection drug use among participants living with HIV. A quarter (27%) of participants living with HIV reported sharing needles in the past six months. We don't know the HIV status of those whom needles were shared with.



"I was trying to deal with pains of the soul ... because I couldn't handle it. When you need to numb the screams from inside your soul, crystal did it."

-Trevor, 50s, HIV+

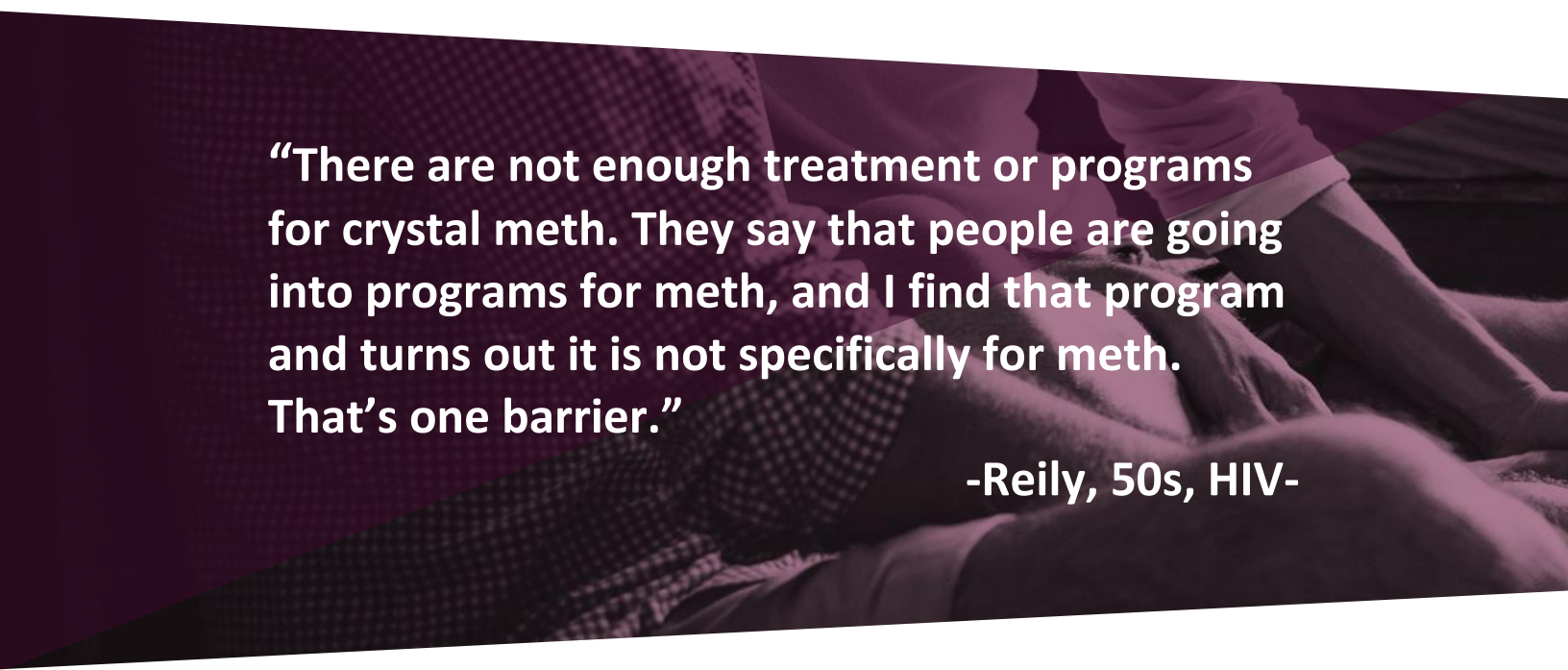
PART 2

Gaps in Services and Supports

Recognizing that participants report a range of interests in accessing services, it is important to understand (1) how people have accessed existing services and supports and (2) whether participants are confident they can access services and supports for their crystal methamphetamine use.

Are men confident they can access the services they need?

Participants were asked about their current confidence level accessing various services and supports. Two thirds (67%) of participants were confident that they would be able to find a program or a counsellor, and the majority (60%) were confident that they could disclose their meth use and a need for help to their doctor. This indicates that physicians and other healthcare providers could be an important partner for linkage to meth use services. About half of participants were confident that they would be able to find a program where they are comfortable (48%).



“There are not enough treatment or programs for crystal meth. They say that people are going into programs for meth, and I find that program and turns out it is not specifically for meth. That’s one barrier.”

-Reily, 50s, HIV-

Figure 4. % Not Confident in Accessing Services by Frequency of Meth Use

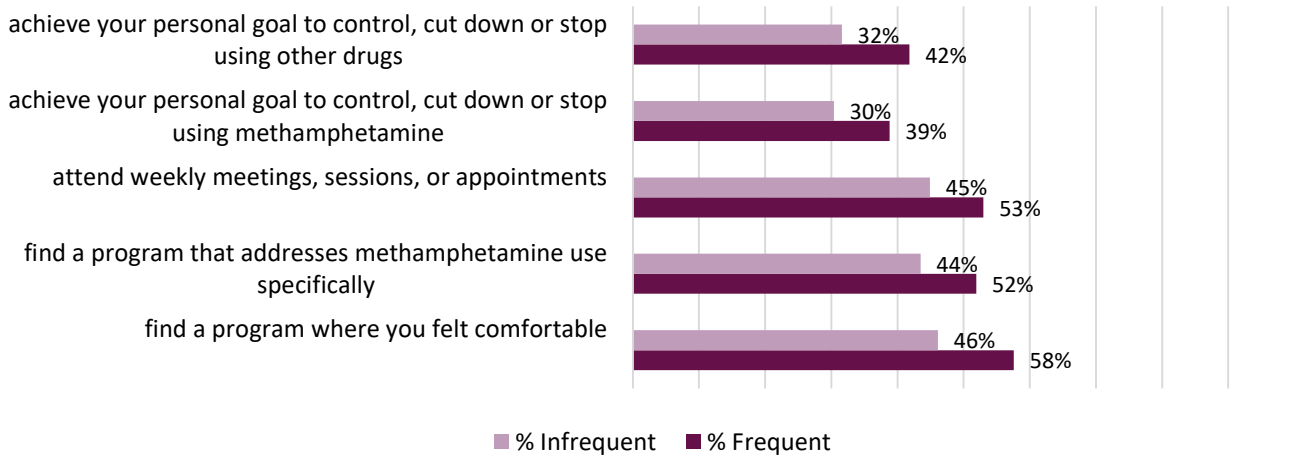
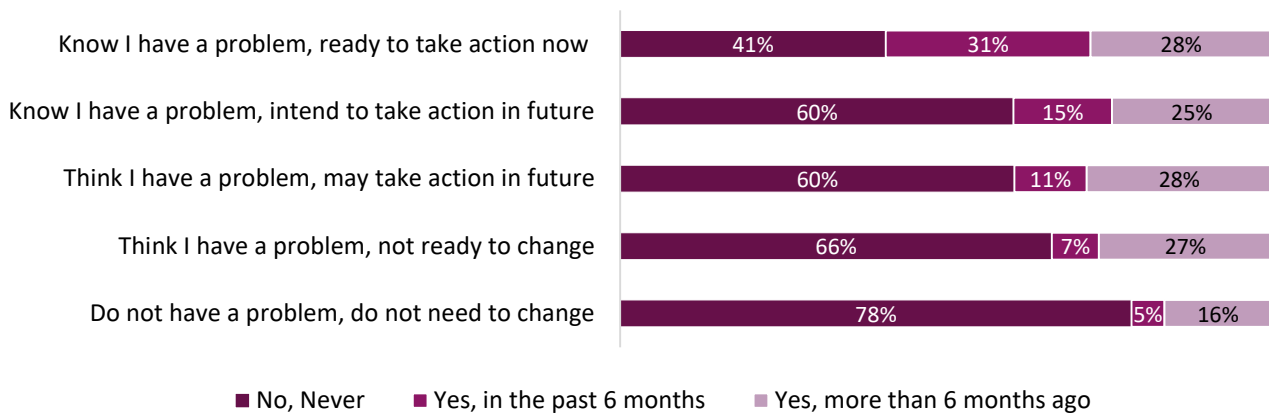


Figure 4 shows participants’ confidence in accessing drug-related services stratified by frequency of meth use. A larger proportion of frequent meth users reported not feeling confident in their ability to complete the various actions mentioned above. Almost 60% of guys who used meth frequently were not confident that they could find a program where they felt comfortable, and approximately half were not confident that they would be able to find a program specifically for meth.

What services and supports have participants accessed?

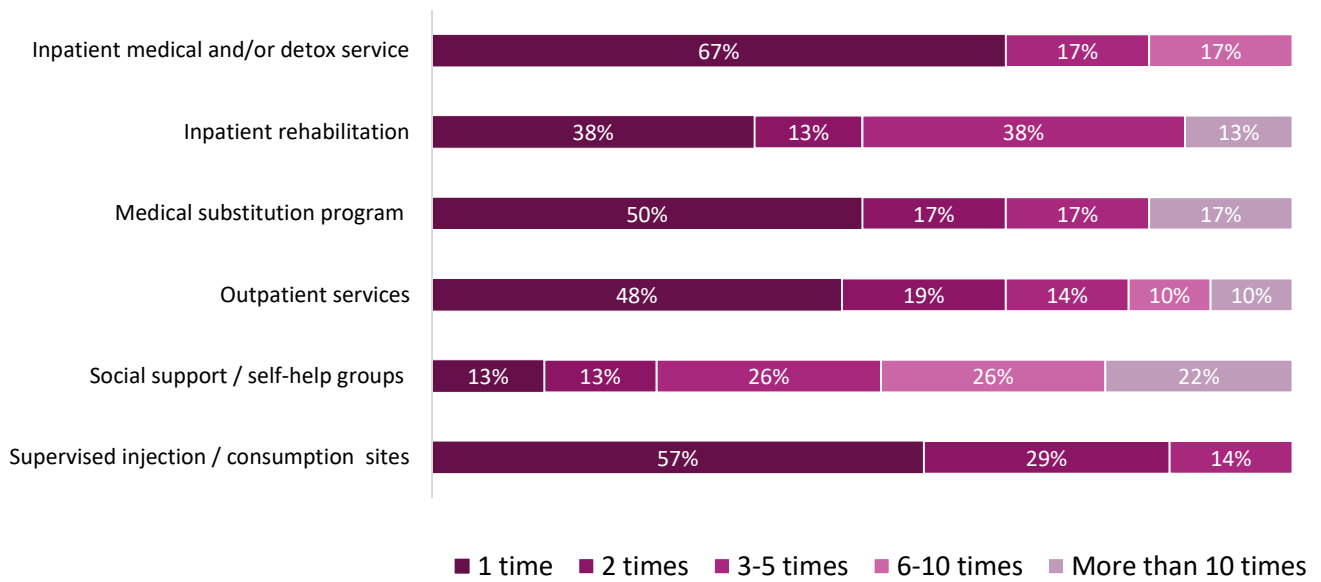
Figure 5. Past Access of Drug-Related Services by Readiness to Change Meth Use



As illustrated by **Figure 5**, though participants indicated that they would feel confident finding a program or counsellor, two thirds (66%) of respondents overall had never received any treatment, counselling, or harm reduction services. When stratified by readiness to make changes to their current meth use, the proportion of participants who have accessed services increased as readiness to change increased. The percentage of respondents who have accessed services was largest among those who reported that their meth use was problematic and that they were ready to act to change their use now; however, two of five (41%) participants in this group had still never accessed any drug-related services.

Among those who had ever used services, **Figure 6** demonstrates that the proportion of participants who had accessed each service a certain number of times in the previous six months differed. The most commonly accessed services were social support and self-help groups, with 32% of respondents who had accessed drug-related services in the past six months reporting that they have used this before. Social support services and self-help groups were also the services that were accessed more than once the most. 30% of drug-related services users had used outpatient services, 11% had used inpatient rehabilitation, 10% had used supervised injection and consumption sites, 8% had used medical substitution programs, and 8% had used inpatient medical or detox services.

Figure 6. Frequency of Use of Drug-Related Services in the Past Six Months



PART 3

Program Preferences

Given that a considerable proportion of men are interested in accessing help and feel that crystal meth is a problem in their life, we sought to understand (1) what supports and services for crystal meth should look like, (2) what role harm reduction should play, and (3) what role peers should play. For the purposes of this project, peers were defined as gbMSM who have lived or living experience with meth use.

What do participants want supports and services to look like?

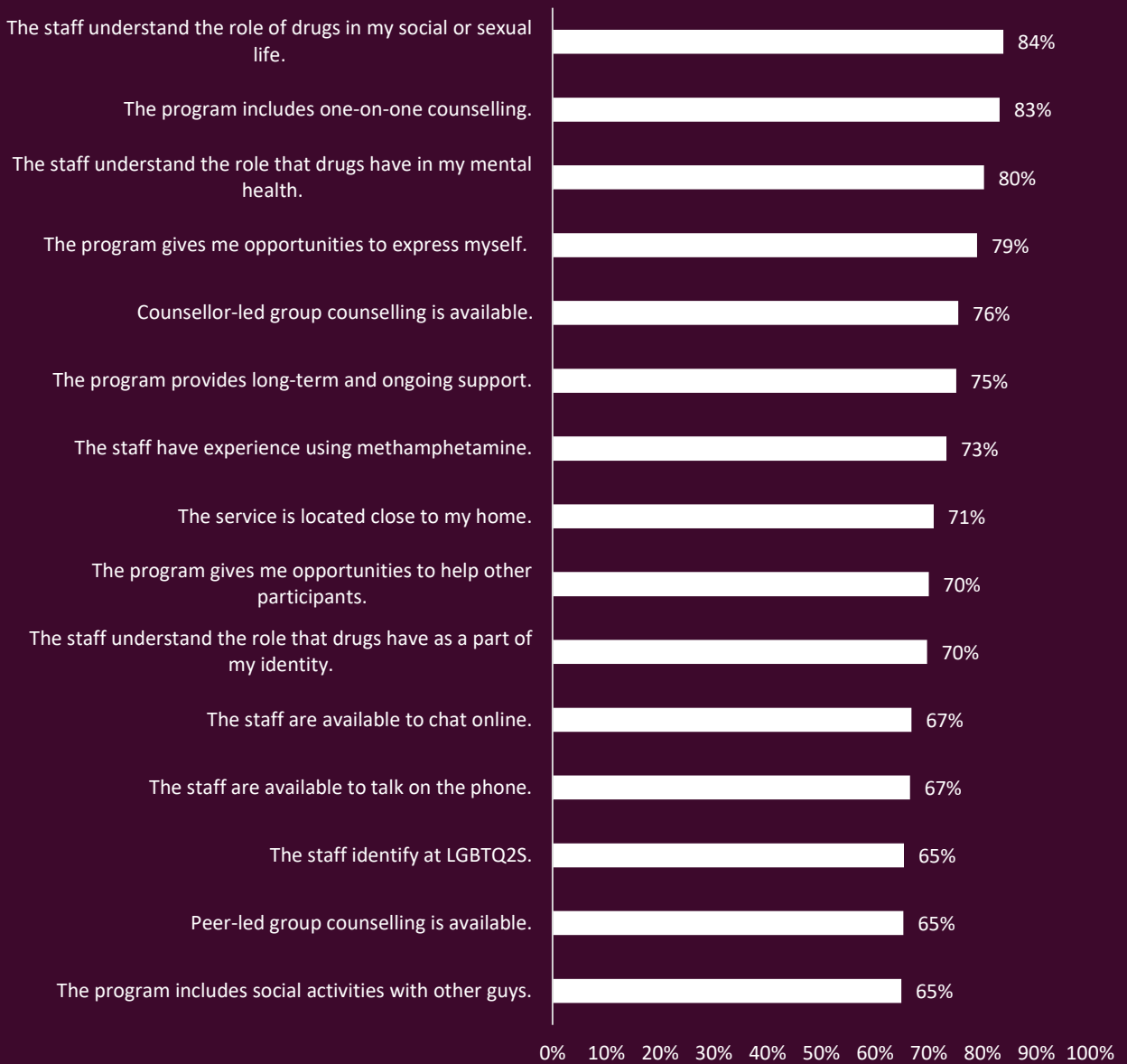
Participants were asked to rate how important they thought various potential features of a meth program would be to them, as shown in **Figure 7**. This information can be used to inform the creation of meth use programs or services based on the concept of culturally safe care. Our definition of culturally safe care means to ensure that gay, bisexual, and queer men who have experience with crystal meth use participate in the creation of the care that they and their peers will receive.⁽⁶⁾

Certain treatment preferences included in the survey were targeted towards specific subgroups. Among participants who were not white, 15% rated that having the other participants the same ethnicity as them as important. In addition, 29% of participants who identified as Indigenous rated that having the staff identify as Indigenous was important. Among participants who were not completely out to everyone in their lives, 25% rated not having to disclose their sexuality as important.

The most important characteristics were related to the staff having experience using meth (i.e., were peers) and the staff having a thorough understanding the different roles of meth use in the lives of gbMSM, such as in participants' social, sexual, or communal life and mental health. Important program characteristics also included having both group and one-on-one counselling available, and that support should be ongoing with no specific end date. As one interview participant put it:

“With the one-on-one you might say things that you wouldn’t say in a group setting. And in a group setting you might hear things that help you out, right? ... So it works with the two of them.” (Matthew, 30s, HIV-)

Figure 7. 15 Most Important Characteristics in a Program Addressing Meth Use



In addition to the characteristics already identified above, participants shared concrete expectations for program frequency and duration. In summary, 73% of guys indicated that the ideal duration of one session or activity would be 1 hour or 90 minutes; 76% indicated that they would like to have a session once every few days or once a week. A larger proportion of frequent users preferred less time between sessions, with 66% of frequent meth users compared with 47% of infrequent users preferring to have sessions daily or every few days. Notably, 71% of participants indicated that it was important for the program to provide long-term and ongoing support with no set end date. This was also emphasized by many interview respondents, who noted that the time it takes to make substantial progress differs depending on the individual. Programs should reflect this, since as one respondent put, “it could start getting good and then all of a sudden your sessions are up.” (Matthew, 39, HIV-). In addition, another respondent said they would like programs to continue “until I feel better” (Logan, 50s, HIV-).

A common theme from interviews was that respondents felt that most of the programs that were offered to them were centered around detoxing or abstinence. Participants mentioned they accessed these programs, but were kicked out for using. This highlights the need to ensure that services targeted toward gbMSM who are not ready to completely end their meth use are available, so that all gbMSM using meth can be met ‘where they are at’. Harm reduction services, which can be defined as client-centered approaches to reduce physical and social harms that accompany drug use, without having to quit completely.⁽⁷⁾ For example, harm-reduction services, such as safe injection sites and counselling that does not require abstinence, are crucial resources that should be available. One respondent described his experience with an addictions counsellor who only believed in abstinence-based treatment:

“My addictions counsellor doesn’t believe in the harm reduction model. It’s either abstinence or nothing, you know, and he said to me, if you are continuing down the harm reduction [path] I’m going to have to stop seeing you and it needs to be accommodation for all kind of models.” (Philip, 51, HIV+)

The idea of meeting people where they are at is part of the concept known as the continuum of care⁽⁸⁾. In the context of meth use in PnP, this can be defined as providing a number of diverse but interconnected substance use interventions for gbMSM, including preventive interventions, harm-reduction-based services, and treatment options so that it is possible to meet folks where they are in terms of their readiness to reduce or quit crystal meth use.⁽⁸⁾ Creating a network of care options based on a continuum of care model will help reach those who may have been previously left behind by one-size fits all programs. This includes ensuring that these different services communicate with one another so that participants are able to start with the programs and services that meet their most immediate needs and current circumstances, and as their needs change, they can move seamlessly to other services in the program continuum.

What is the role of peers?

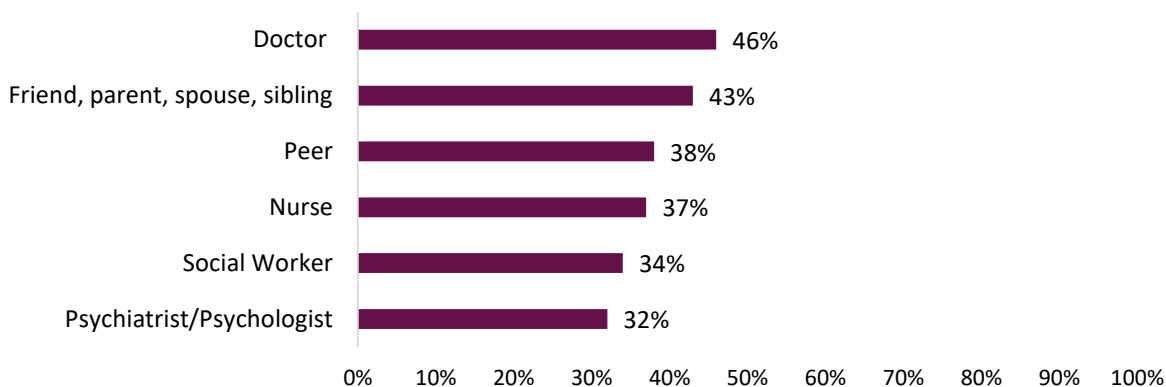
Some of the most important characteristics for participants were related to the staff thoroughly understanding different roles of meth use in the lives of gbMSM, such as the role that drugs play in their social, sexual, or communal life and mental health. Overall, three quarters (73%) of respondents rated having staff who have used meth as important. This was also a common theme among interview respondents, who noted that lived experience allows for empathy and compassion from the staff, which leads to a more productive and comfortable experience. As one respondent put it, peers don’t “hold any stigma because everyone is on the same level” (Drew, 50s, HIV+). Another interview participant described their experience working with meth users as a peer:

“When I tell them, I know exactly what you’re going through. I know the screams at night, I know the sweats, I know the needle up my arm and when I thought that I could not stop they look at me and go oh, wow. And now I’m not doing it nowadays, so there’s hope, there’s hope.” (Trevor, 50s, HIV+)

Who should ask men about their methamphetamine use?

To ensure that gbMSM are comfortable accessing substance-use related care, it is crucial the individuals providing it deliver culturally safe care. It is also important that providers or anyone else who wants to discuss meth use with a patient should always obtain consent before doing so; for example, providers can ask, “would you be okay to talk about your substance use with me?” As such, we asked participants who they felt comfortable with asking them about their meth use (see **Figure 8**).

Figure 8. % Comfortable if Each Individual Asked About Meth Use



The proportion of participants who would be comfortable with different individuals asking them about their meth use did not fluctuate substantially, with a range from 32% for psychiatrists or psychologists to 46% for doctors. Previous research suggests that perceived stigma, mistrust, and past negative experiences among gbMSM with health care providers may partially explain these findings.⁽⁹⁾ A larger proportion of guys living with HIV reported feeling comfortable if their family doctor asked them about their meth use when compared with HIV-negative guys (48% versus 39%).

Based on interviews with guys living with HIV, this may be due to having long-term, supportive relationships with doctors who have experience working with gbMSM and individuals who use substances, such as HIV specialists and doctors working in sexual health clinics. As one respondent noted, their doctor is an HIV specialist who is familiar with PnP and working with gbMSM and has become the “primary healthcare person in [their] life” (Reilly, 55, HIV-) that they can talk to about meth use and the PnP scene. Another participant noted their positive experience with a family doctor familiar with gbMSM and PnP:

“I’m finding having a family doctor at a clinic that typically deals with gay men and is aware of uh, the whole party and play scene and just basically gay lifestyle, have a better understanding of the behaviors and why people engage in [them] than what you would get at just a regular family doctor or practitioner.” (Zack, 30s, HIV-)

Among HIV-negative guys only, doctors still had the highest percentage that were comfortable if they were to ask them about their meth use at 50%, indicating that with consent, doctors should ask.

PART 4

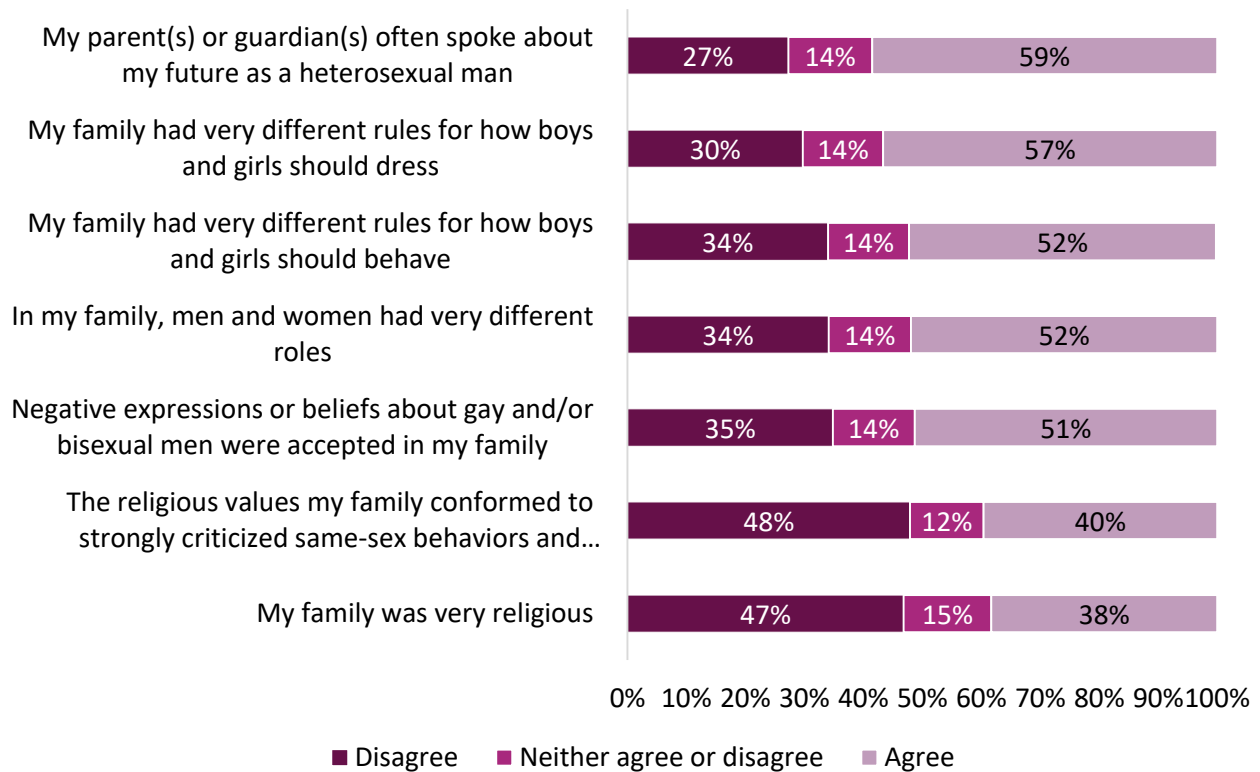
The Role of Trauma and Stigma

Meth use among many gbMSM was shaped by shame, stigma, and the need to cope with traumatic experiences. Previous studies have reported links between experiencing homophobia and increased frequency of meth use.⁽¹⁰⁾ In addition, life course factors such as adverse childhood experiences and sexual, physical, or emotional abuse have been linked to substance use and negative health outcomes among gbMSM.⁽¹¹⁾ Because of this, we explored the relationship between participants' meth use and **(1)** their experiences of homophobia and heterosexism, **(2)** traumatic experiences in childhood and later life, and **(3)** stigma related to substance use, and how these impact substance use patterns and willingness to reach out for help.

How do homophobia and heterosexism shape meth use?

Homophobia is defined as “negative attitudes toward gay or homosexual people”⁽¹²⁾ and heterosexism is the belief that heterosexuality is normal and ideal when compared with homosexuality.⁽¹³⁾ Both homophobia and heterosexism have previously been linked to poor access to health care and lower quality of care.⁽¹⁴⁾ Harmful beliefs concerning homosexuality and bisexuality, expectations of living a stereotypical “heterosexual” lifestyle, and traditional gender role beliefs were common in respondents' childhood environments, as illustrated by **Figure 9**.

Figure 9. Prevalence of Negative Beliefs Concerning Homosexuality/Bisexuality and Gender Norms During Childhood



Family rejection is a key determinant of psychosocial health among gbMSM.⁽¹⁵⁾ Religious beliefs held by family members that criticize same-sex behaviours and identities were reported by 40% of respondents. Interview respondents noted that growing up in a family with conservative religious values “is not the ideal environment for anyone who is going to be gay to come out of” (Nolan, 61, HIV+).

Half of survey participants reported traditional views of binary gender roles were present during childhood, such as rules for how boys and girls should dress (57%) and behave (52%). These beliefs often manifested into harmful experiences for interview respondents, such as being mocked for being effeminate by family members or being denied desired experiences because they were traditionally for girls. As one respondent recalled:

*“My earliest childhood memory is my sister, who was 5, dancing with my dad. And there are people, guests, over. He is teaching her to dance, and I want to do it too. So she finishes, and I got there. He didn’t want to do it because I was a boy, and boys don’t dance together. A feel of rejection, devastation I can still feel that in my chest.”
(Rudy, 50s, HIV+)*

What types of traumatic experiences were reported?

Three main categories of traumatic experiences were measured in the survey: **(1)** childhood trauma, **(2)** trauma in romantic relationships, and **(3)** stressful life experiences.

Childhood Trauma (before 18 years old)

The most common traumatic childhood experiences reported by guys were verbal and physical abuse by a parent or guardian, with two thirds of participants reporting these experiences. One interview respondent explained how having a verbally and physically abusive brother made a lasting negative impact on his own perceptions of his sexuality and identity as a gay man:

“I have an older brother who when I was a teenager became verbally abusive, physically abusive, so all of a sudden I got this kind of idea in my mind – or I sort of created all of these core beliefs in my brain about not being good enough, all this shame and guilt around being gay.” (Chris, 30s, HIV+)

Experiences of sexual abuse during childhood were reported by a substantial number of participants, with a quarter (26%) indicating they had been sexually abused. Interview respondents expressed that these experiences had lasting effects on them throughout their lives. As one noted, having experienced sexual abuse “led to a lot of guilt and shame.” (Simon, 50s, HIV+)

Trauma from Romantic Relationships (past or current)

A substantial proportion of participants reported arguments that escalated to acts of physical intimidation such as destruction of property and punching (40%), and feeling afraid, isolated, or trapped within a relationship (38%). Feeling pressured by a past partner to have sex without a condom or being lied to about a past partner’s HIV status was reported by 19% of participants.

Stressful Life Experiences

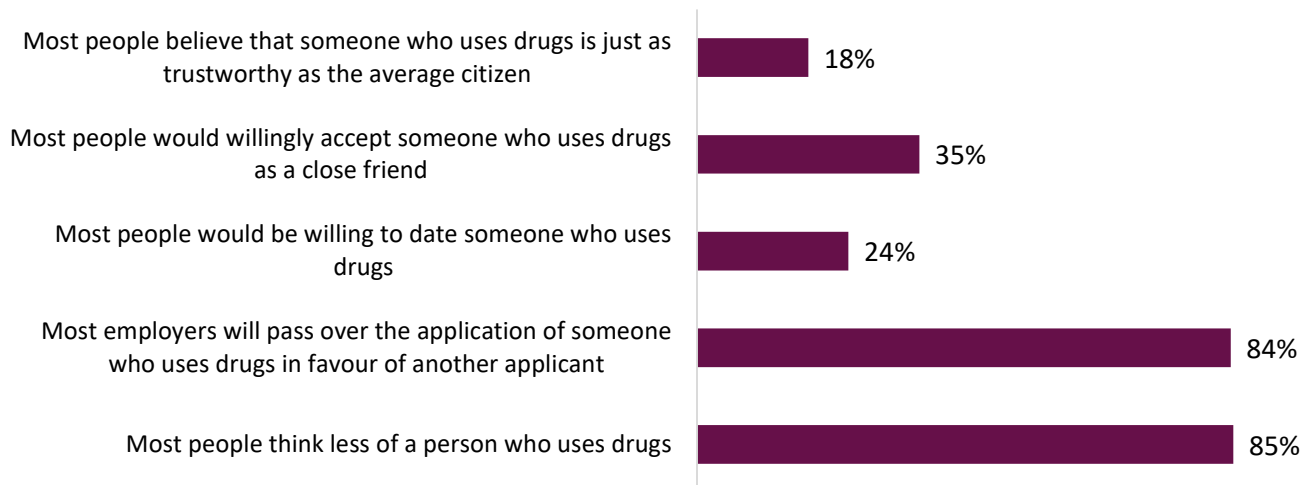
In the past year, half (49%) of participants experienced sex difficulties, half (47%) had changes in sleeping habits or conditions, and 44% had a change in their financial state. Longer than a year ago, the most common stressful life experiences were separation or end of a relationship (53%) and death of a close family member (51%). One interview respondent described how the death of his mother had lasting effects on his mental health and wellbeing:

“My mom passed away a year ago, it is a big part of me that doesn’t live anymore... A really, really big part of me, that doesn’t want to live anymore. That has been really hard to navigate.” (Rudy, 50s, HIV+)

How does stigma towards substance use impact services?

Participants indicated that stigma towards people who use drugs is present in day-to-day social and professional situations, as illustrated by **Figure 10**.

Figure 10. % Agreed with Perceived Stigma Toward People Who Use Drugs



Interview participants also noted experiencing stigma in their social lives. One respondent recalled disclosing his meth use to a new friend:

“I did tell someone one time that I was struggling with meth use, and he had a serious problem with that. Like he wasn’t happy to hear the fact that I use crystal meth, and that ended pretty much any possibility of future friendship with him.” (Carter, 30s, HIV-)

A common theme expressed during interviews was feeling stigmatized by health care providers due to drug use. In addition, many interview participants mentioned not disclosing their meth use to their primary health care provider due to “feeling embarrassed” and not wanting to tell them because they “might get a big lecture.” (Logan, 50s, HIV-).

Previous research has noted that fear of experiencing stigma is often a barrier to accessing healthcare and drug-related services, which can lead to avoidance, delaying, or even disengagement with important treatment completely.⁽¹⁶⁾ It is therefore crucial that healthcare providers ensure a safe and affirming space to engage about meth use in order for them to receive whatever care they need.

“You know, you can’t have some of these conversations with your family healthcare provider. You can’t do it... Because they have a bias against drug users. Bottom line.”

- Nolan, 60s, HIV+



PART 5

Conclusion & Recommendations

Conclusion

Through analyzing 33 semi-structured qualitative interviews and 780 online surveys from gbMSM who recently used meth, we were able to examine crucial aspects of substance use, what programs and services they felt were currently available to them, what services guys wanted access to in the future, and how past traumas and experiences as well as ongoing stigma impacted their meth use and engagement in care. Based on these analyses, it is clear that treatments and services currently available to gbMSM who use meth do not completely meet their needs. It is necessary to implement different intervention and treatment options that are tailored specifically to this diverse population that take into account the range of unique needs and experiences.

Recommendations

We provide ten recommendations to improve support for gbMSM who use meth:

1. Ensure availability of both one-on-one and group counselling services.
2. Design campaigns and interventions to decrease stigma related to meth use within the broader gbMSM population as well as among healthcare providers.
3. Create broader societal interventions to decrease stigma towards diverse sexualities and restrictive binary gender roles, with recognition of the need for a lifecourse approach and generational differences (e.g. recent improvements don't change the reality of what older gay men experienced as a child decades ago).
4. Harm reduction programs and supplies must affirm and be accessible to gbMSM. This includes supply distribution and exchange services, as well as supervised consumption sites.
5. Involve peers in the creation and implementation of programs, services and activities. This should consider intersections of meth use history, sexual orientation, and HIV status.
6. Train health care providers to secure consent and ask gbMSM about their meth use.
7. Remove set end dates in all substance use programs and services. These should continue as long as participants feel it is needed for improvement to be made. Also ensure network of care options are available to provide retention and continuation in care as needed.
8. Meet each patient where they are at based on their readiness to reduce their use or quit completely or not. Programs are needed that do not require abstinence.
9. Ensure services are trauma-informed, meaning that care providers should understand and be able to help participants address their trauma, including experiences of childhood sexual abuse, heterosexism, and homophobia.
10. Given the social component of meth use among gbMSM, social programming should be provided that allows for connectedness and friendship.

References

1. Methamphetamine (Canadian Drug Summary) | Canadian Centre on Substance Use and Addiction [Internet]. [cited 2020 Aug 17]. Available from: <https://www.ccsa.ca/methamphetamine-canadian-drug-summary-0>
2. Cheng B, Sang JM, Cui Z, Bacani N, Armstrong HL, Zhu J, et al. Factors Associated with Cessation or Reduction of Methamphetamine Use among Gay, Bisexual, and Other Men Who Have Sex with Men (gbMSM) in Vancouver Canada. *Subst Use Misuse*. 2020 Jul 1;55(10):1692–701.
3. Edmundson C, Heinsbroek E, Glass R, Hope V, Mohammed H, White M, et al. Sexualised drug use in the United Kingdom (UK): A review of the literature. *Int J Drug Policy*. 2018 May 1;55:131–48.
4. Ahmed A-K, Weatherburn P, Reid D, Hickson F, Torres-Rueda S, Steinberg P, et al. Social norms related to combining drugs and sex (“chemsex”) among gay men in South London. *Int J Drug Policy*. 2016 Dec 1;38:29–35.
5. Bryant J, Hopwood M, Dowsett GW, Aggleton P, Holt M, Lea T, et al. The rush to risk when interrogating the relationship between methamphetamine use and sexual practice among gay and bisexual men. *Int J Drug Policy*. 2018 May 1;55:242–8.
6. Pauly B, Parker J, McLaren C, Browne J. CREATING Culturally Safe Care. 2013;6.
7. Harm Reduction [Internet]. [cited 2020 Sep 21]. Available from: <https://ontario.cmha.ca/harm-reduction/>
8. Bakker I, Knoop L. Towards a continuum of care concerning chemsex issues. *Sex Health*. 2018;15(2):173–5.
9. Eaton LA, Driffin DD, Kegler C, Smith H, Conway-Washington C, White D, et al. The Role of Stigma and Medical Mistrust in the Routine Health Care Engagement of Black Men Who Have Sex With Men. *Am J Public Health*. 2014 Dec 18;105(2):e75–82.
10. Li MJ, Okafor CN, Gorbach PM, Shoptaw S. Intersecting burdens: Homophobic victimization, unstable housing, and methamphetamine use in a cohort of men of color who have sex with men. *Drug Alcohol Depend*. 2018 Nov 1;192:179–85.
11. Herrick AL, Lim SH, Plankey MW, Chmiel JS, Guadamuz TT, Kao U, et al. Adversity and Syndemic Production Among Men Participating in the Multicenter AIDS Cohort Study: A Life-Course Approach. *Am J Public Health*. 2013 Jan;103(1):79–85.
12. Williamson IR. Internalized homophobia and health issues affecting lesbians and gay men. *Health Educ Res*. 2000 Feb 1;15(1):97–107.
13. Goodrich KM, Selig JP, Crofts G. An Examination of the Heterosexism Scale. *J Homosex*. 2014 Oct 3;61(10):1378–92.
14. Morrison S, Dinkel S. Heterosexism and Health Care: A Concept Analysis. *Nurs Forum (Auckl)*. 2012;47(2):123–30.
15. Garcia J, Parker C, Parker RG, Wilson PA, Philbin M, Hirsch JS. Psychosocial Implications of Family and Religious Homophobia: Insights for HIV Combination Prevention among Black Men who have Sex with Men. *Health Educ Behav Off Publ Soc Public Health Educ*. 2016 Apr;43(2):217–25.
16. Salamat S, Hegarty P, Patton R. Same clinic, different conceptions: Drug users’ and healthcare professionals’ perceptions of how stigma may affect clinical care. *J Appl Soc Psychol*. 2019;49(8):534–45.

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