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COMMUNITY REACTIONS TO CAMPAIGNS ADDRESSING CRYSTAL METHAMPHETAMINE USE AMONG GAY AND BISEXUAL MEN IN NEW YORK CITY*

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Abstract

Crystal methamphetamine (*aka* "crystal meth") use with high-risk sex has become an emerging health problem for gay and bisexual men in New York City since the late 1990s. Public health campaigns were eventually developed to encourage gay and bisexual men to avoid or reconsider using crystal meth. Reactions to three campaigns were measured with a cross-sectional survey administered in 2004. Among an ethnically-diverse sample of 971 gay and bisexual men, 61.8% reported seeing the campaigns. Those who reported ever using crystal meth, recent use, and recent use with sex were significantly more likely to have seen the campaigns. In general, white men, HIV-negative men, and men not currently using crystal meth responded more positively to the campaigns than their counterparts; yet, more men of color reported having discussions with partners and friends about their crystal use as a result of these campaigns. Implications for researchers and practitioners are discussed.

The National Survey on Drug Use and Health (NSDUH) revealed that, in 2004, over 19 million Americans ages 12 and over (i.e., 8% of this population) were estimated as current illicit drug users (i.e., drug use within the month prior to the survey) (SAMHSA, 2005). More specifically, the regional rate of current illicit drug use reported for the Northeast (i.e., Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, Pennsylvania, and New York) was 8.4% (SAMHSA, 2005). Regarding stimulant use, over 1.2 million people ages 12 and over reported current use of these drugs; almost half (583,000) were methamphetamine users (SAMHSA, 2005).

Recent media coverage has brought much attention to the negative impact of crystal methamphetamine (or "crystal meth") use on the biopsychosocial health of many Americans. An article from *Newsweek* magazine refers to the surge in crystal meth use as "America's new drug crisis" (Jefferson, 2005). A recent survey of law enforcement agencies in 45 American

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states highlighted crystal meth use as the nation's top drug problem (O'Bryan, 2005). This problem has even prompted United States government officials to pass a law that severely limits the amount of pseudoephedrine sold over the counter at numerous retailers around the country; pseudoephedrine, the main ingredient in many cold and allergy medications, is used to manufacture crystal meth (Associated Press, 2006). Meanwhile, recent studies have documented how rates of crystal meth use among gay and bisexual men have been steadily increasing since the late 1990s (Frosch, Shoptaw, Huber, Rawson, & Ling, 1996;Nanín & Parsons, 2006;Reback, Larkins, & Shoptaw, 2004;Semple, Patterson, & Grant, 2002).

Crystal meth is also known as "Tina," "crystal," "ice," and "speed," among other names (Halkitis & Parsons, 2002;Jones, 2005;Nanín & Parsons, 2006). Its use is feared to be reaching epidemic levels and driving increases in HIV infections and other STIs, including syphilis, due to unsafe sexual practices among some MSM (men who have sex with men) (Jacobs, 2002;Nanín & Parsons, 2006;Purcell, Moss, Remien, Parsons, & Woods, 2005;Purcell, Parsons, Halkitis, Mizuno, & Woods, 2001;Urbina & Jones, 2004;Wong, Chaw, Kent, & Klausner, 2005). MSM in San Francisco who report crystal meth use are at least three times more likely to be living with HIV (Gordon, 2005). A recent San Francisco study reported HIV incidence of 6.3% per year among a sample of 290 MSM meth users compared to 2.1% per year among a sample of 2701 non-meth users (Buchacz et al., 2005). In addition, HIV-positive MSM methamphetamine users reported more acts of unprotected receptive anal sex with HIV-negative or unknown status partners and reported being twice as likely to have unprotected anal sex with partners of HIV-negative and unknown status (Purcell et al., 2005).

Crystal meth use may be driven by numerous factors, some which may be perceived by users as positive ones. The drug has been described as increasing sexual arousal, lowering inhibitions, increasing self-confidence, and influencing decisions to have unsafe sex with partners (Jones, 2005;Semple et al., 2002;Semple, Patterson, & Grant, 2003;Shoptaw et al. , 2005*)*. This drug is popular among gay and bisexual men for use in PnP, or "Party-n-Play."(i.e., drug use before and during sexual activity) (Hirshfield, Remien, Humberstone, Walavalkar, & Chiasson, 2004;Nanín & Parsons, 2006). In addition to smoking and snorting the drug, some MSM report administering the drug anally (Halkitis, Parsons, & Wilton, 2003;Parsons, 2005). This type of administration of the drug along with unprotected "marathon sex" with numerous partners can damage the rectal lining and increase the likelihood of HIV and other STI transmission (Semple et al., 2002).

Use of crystal meth has made its way eastward across the United States, heavily impacting states, like New York and Florida (ASTHO, 2005). Toward the late 1990s, crystal meth became an emerging drug of choice among a significant number of gay men on the East coast, particularly in New York City (Halkitis, Parsons, & Wilton, 2003). Most published articles on crystal meth use among gay and bisexual men focus on samples from the West coast; recent studies in Miami (Kurtz, 2005) and New York (Nanín & Parsons, 2006) have described what appears to be an emerging phenomenon among East coast gay men. A recent study of a community-based sample of MSM in New York City found a slight decrease in lifetime use of crystal meth among MSM (19.9% in 2003 vs. 20.5% in 2002), but increased recent use (10.6% used meth in the 3 months prior to survey administration vs. 7.8% in 2002) (Nanín & Parsons, 2006). Because of these and similar results in other studies, New York City health advocates are forging ahead with efforts to combat this emerging public health issue (New York City Department of Health and Mental Hygiene, 2004;Reuters, 2004). Considering the increased documentation of HIV risk behaviors linked to crystal meth use (Halkitis, Parsons, & Stirratt, 2001;Nanín & Parsons, 2006;Semple et al., 2002;Semple et al., 2003), the response has never been more timely.

A significant response from the service provider community concurrently emerged along with the documented rise in HIV risk behaviors and crystal meth use. More than 20 Crystal Meth Anonymous (CMA) meetings are now conducted weekly at various locations around New York City (Owen, 2004). In addition, just as in other parts of the country with significant populations of crystal meth-using MSM [e.g., Boston, Fort Lauderdale, Los Angeles, Provincetown, and Seattle (Kaufman, 2003;O'Bryan, 2005)], community activists and health professionals in New York City have developed public health messages used in social marketing campaigns to help stop the rise of crystal meth use among gay male New Yorkers (ASTHO, 2005;Douglas, 2005).

Social marketing and similar public health campaign approaches have been used widely to promote healthy behaviors among specific sectors of large communities (e.g., adolescents, women, and gay men) (Andreasen, 1995;Kotler, Roberto, & Lee, 2002;Siegel & Doner, 1998;Weinrich, 1999). Social marketing is defined as "a process of designing, implementing, and controlling programs to increase the acceptability of a pro-social idea among population segments of consumers" (Dearing et al., 1996, p. 345). It is an approach that, until recently, was rarely used with marginalized populations (e.g., gay and bisexual men) (Dearing et al., 1996), yet it is recognized by the United States Centers for Disease Control and Prevention (CDC) as an effective health communication strategy that works well with health education and health promotion for various populations (CDC, 2005).

To reach large communities of gay and bisexual men, this approach can be less expensive and more cost-effective for heightening awareness of important health and psychosocial issues. These types of community-oriented health communication strategies have been widely used and can be effective when health messages are disseminated in a culturally-competent manner with language and images that community members can comprehend and relate to (GLMA, 2001). For example, Montoya et al. (2005) found that an effective social marketing campaign in San Francisco helped in increasing syphilis testing rates among gay and bisexual men because of its frank approach and creative imagery.

Anti-crystal meth social marketing campaigns in New York City started in early 2004 when activist Peter Staley used his own money to fund a campaign in response to what he perceived as a situation that was getting out of control in the gay male community (Osborne, 2003: Owen, 2004). Staley's campaign consisted of colorful, eye-catching phone booth posters and magazine ads ("Buy Crystal, Get HIV For Free," see Figure 1). Public reaction was intense on both sides; some supported his need to raise awareness while others accused him of trying to stagnate gay men's sexual liberation (Owen, 2004).

As a result, public forums were conducted by a newly-formed grassroots group called the HIV Forum, which included Staley. These community forums allowed gay and bisexual men who were concerned about this issue to voice their concerns as well as learn more about this drug (Owen, 2004). As a result of rising concern, the HIV Forum and Gay Men's Health Crisis followed with public health campaigns to address the issue (refer again to Figure 1) (Osborne, 2004;Owen, 2004). To date, there has been no empirical study to assess the gay community's reactions to these pioneering campaigns. The purpose of the present study was to fill this void in the literature.

METHOD

Participants and Procedure

In fall 2004, a cross-sectional brief street-intercept survey method (Miller, Wilder, Stillman, & Becker, 1997) was used to administer a questionnaire to 1617 participants at two large-scale gay, lesbian, and bisexual (GLB) community events in New York City through the Sex and

Love v3.0 Survey Project. This approach to collecting data has been used in numerous studies (Carey, Braaten, Jaworski, Durant, & Forsyth, 1999;Chen, Kodagoda, Lawrence, & Kerndt, 2002;Kalichman & Simbaya, 2004a,2004b), including those focused on GLB persons (Benotsch, Kalichman, & Cage, 2002;Kalichman, et al., 2001) and has been shown to provide data that are comparable to those obtained from other more methodologically rigorous approaches (Halkitis & Parsons, 2002). The two events required paid admission to gain entry. The Institutional Review Board at the second author's home institution approved the project.

At both two-day events, the research team hosted a booth, and each person who passed by the booth was actively approached by outreach staff trained in survey administration and working with the GLBT community. Potential participants were provided with information about the project and offered the opportunity to participate. The response rate was high, with 84.4% of individuals consenting to participate. Those who consented and completed the 15–20 minute survey were provided with a voucher for free admission to a movie as an incentive. To help ensure their confidentiality, participants were given the survey on a clipboard so that they could step away from others to complete the questionnaire. In addition, upon completion, participants deposited their own survey into a secure box at the booth.

Complete surveys were obtained from 1214 gay and bisexual men over the age of 18. The data analyzed for this study is based upon the 80% of the men in the sample who provided zip codes from NYC, northeast NJ, Long Island or Westchester/Rockland counties (n = 971). Even though the campaign was implemented only in Manhattan, these zip codes represent the residence areas of respondents who visit venues in Manhattan and were potentially exposed to these campaigns.

Measures

The larger survey assessed a broad range of sexual behaviors, history of sexually transmitted infections, substance use, physical health, and a series of scales related to psychological health and well-being. The researchers chose specific scales from the survey in order to produce and analyze the data reported in this article.

In order to measure the relationship between unsafe sexual behavior and crystal meth use, one of the most pertinent issues addressed by the campaigns discussed in this article, respondents were asked whether or not they identified as "barebackers." The practice of barebacking refers to intentional as well as unintentional unprotected sex, primarily anal sex (Bimbi & Parsons, 2005;Silverstein & Picano, 2003). Responses to our survey item were based on a dichotomous "Yes/No" response scheme.

Crystal meth use for each of the following time periods was also assessed using items with "Yes/No" response schemes: lifetime use ("ever used in your life?"), recent use ("used in the last 3 months?), and recent use with sexual activity, colloquially referred to as "Party-n-Play," or "PnP" ("used with sex in the last 3 months?").

Respondents were also asked to mark "yes" or "no" to an item assessing exposure to the anti-crystal meth campaigns: "Have you seen any of the following advertisements: 'Crystal Meth: Nothing to Be Proud Of,' 'Buy Crystal, Get HIV Free,' and 'Crystal Meth: Know the Risks'?" Because all the campaigns were disseminated simultaneously, the research did not set out to assess exposure and reaction to each individual campaign. Those who answered in the affirmative were then asked five questions regarding their reactions to the advertisements (e.g., "These ads made me think about not starting to use crystal or cutting down on my use," These ads made me want to talk to my friends/partner about their use of crystal"). The items were developed based on information gathered from gay press reports on community reactions to

these campaigns (e.g., Owen, 2004). In addition, the items set out to test diffusion of messages disseminated by these campaigns. Responses were coded on a Likert-type scale ranging from 1 (strongly disagree) to 4 (strongly agree). Exploratory factor analyses revealed that the 5 items loaded on a single factor accounting for 47.36% of the variance. The scale achieved an alpha of .72. (See Table 1 for specific survey items.)

For demographic characteristics, respondents were asked to indicate their age, sexual identity, and race/ethnicity, by checking all that apply. Response categories to race/ethnicity included "European/White," "African-American," "Asian/Pacific Islander," "Hispanic/Latino," and "Other (Specify)." The latter four categories comprise the new category, "men/MSM of color," which was used in data analysis. (*Please note:* This last category is represented as "non-white" in Table 2.)

Analyses

Data were entered into an SPSS database. These data were subsequently verified by project staff for accuracy. In addition to routine frequency distributions determined for demographic variables, chi-square statistical tests with relevant odds ratios were conducted to test for differences between subgroups in the sample. Because there were no differences in key variables by the two recruitment events, the data for this study were combined for all analyses.

RESULTS

The majority of the sample (93.7%) was gay-identified, with the remainder identifying as bisexual. Most reported having full-time jobs (71.4%; $n = 688$) and living in Manhattan (54.3%; $n = 527$). Other sample characteristics, including age, education, self-reported HIV status, and income, are presented in Table 3. The majority of respondents reported being HIV negative, with 73.3% ($n = 561$) of the overall sample having tested negative within the last year. Over seven percent of the sample (7.8%; $n = 76$) reported never being tested or not knowing their status and 13.4% ($n = 130$) reported being HIV positive, a third of which learned about their HIV status 4 years ago or sooner.

Respondent Crystal Meth Use

"Crystal meth use ever" was reported by 19.3% of the sample. Recent use (i.e., in the last 3 months) was reported by 9.4%. Recent use with sex (i.e., "PnP") was reported by 73.4% of users (or 6.9% of the total sample). No significant racial, educational, or employment differences in use of crystal were found; *however*, in terms of HIV serostatus, HIV positive men were significantly more likely to report ever using crystal meth (38.7% vs. 16.3%, OR = 3.23, $p < .001$) and recent use of crystal (22.7% vs. 7.4%, OR = 3.66, $p < .001$) as well as recent PnP behaviors (16.8% vs. 5.5%, OR = 3.49, $p < .001$).

Manhattan residents were more likely than residents outside of the borough to report ever using crystal meth (25.0% vs. 12.5%, OR = 2.35, $p = .000$), recent use (11.9% vs 6.4%, OR = 1.98, $p < .01$), and recent PnP behaviors (9.2% vs. 4.1%, OR = 2.40, $p < .01$). Men who reported annual incomes of less than $80,000 were less likely than men making more than $80,000 annually to report ever using crystal meth (28.4% vs. 16.6%, OR = 2.00, $p = .000$), recent use (14.8% vs. 7.7%, OR = 2.10, $p < .01$), and recent PnP (11.6% vs. 5.3%, OR = 2.33, $p < .01$). (Note: All other income categories were statistically different from the "$80,000 and over" category; thus, the former categories were collapsed to determine appropriate odds ratios.)

Exposure and Reactions to Anti-Crystal Campaigns

A total of 61.8% of the sample reported being exposed to the anti-crystal campaigns (i.e., seeing any of the three campaign slogans previously mentioned). No differences were observed in campaign exposure in terms of data collection site, race, HIV status, or age. Those who reported lifetime use (82.6% vs. 64.5%, OR = 2.61), recent use (85.5% vs. 64.8%, OR = 3.10), and recent PnP use of crystal (85.2% vs. 66.2%, OR = 2.95) were significantly more likely to have seen the campaigns ($p < .001$).

The proportions of the sample that answered in the affirmative for each of the five items regarding the campaigns are presented in Table 1. Even though many men responded positively to the campaigns, there was a sizable proportion of respondents (11.9%) who reported wanting to use crystal *more* as a result of seeing the campaigns.

Summary of Significant Differences for Survey Items

Table 2 summarizes various differences between groups for each of the survey items that assess reactions to the New York City anti-crystal meth campaigns. Results show that white gay and bisexual men in comparison to gay and bisexual men of color (represented as “non-white” in the table) were more likely to agree with statement 1 (“Think about not starting to use crystal or cutting down on my use”) and statement 2 (“Glad someone was doing something about crystal use in the gay community”), as were HIV negative men and men who indicated they were not barebackers. Among men who reported ever using crystal, those who had NOT used crystal recently or NOT used recently with sex were more likely to agree with statement 2, while men who participated in recent crystal use with sex were more likely to agree with statement 3 (“Want to start using crystal or to use crystal more”). Among all men in the sample, men of color (“non-White”) were more likely to agree with statement 4 (“Want to talk to my friends/partner about their use of crystal”). Men who did NOT identify as barebackers were also more likely to agree with statement 5 (“Want to get help to stop using crystal or avoid starting to use”). All resulting *p*-values were less than .05.

DISCUSSION

In this New York City sample, gay and bisexual male Manhattan residents with annual incomes of more than $80,000 reported the most lifetime and recent use as well as recent PnP use of crystal meth. In addition, gay and bisexual male community reactions to the anti-crystal methamphetamine campaigns appear to have been mixed. White men, HIV-negative men and men not currently using crystal responded more positively to the campaigns. The campaign may have intended to reach out to a broader population of gay and bisexual men, including HIV-positive men and men of color, but the present study shows it was less effective in this sense.

It must be mentioned that the campaign materials featured white men and were disseminated mostly in Chelsea, a neighborhood in New York City with a significant proportion of white gay and bisexual male residents. Over a decade ago, Stall (1994) called for a re-evaluation of HIV prevention efforts, including public health campaigns, to focus on expanding its messages beyond the reach of middle class, white gay men in order to effectively win the battle against HIV/AIDS. Results of the current study should encourage creators of anti-crystal meth campaigns in New York City and other urban areas in the United States to include communities of color as well as communities of current meth users in the planning and development process of these campaigns in order reach these communities more effectively.

As reported in this study, more men of color responded positively to the item asking about having discussions with partners and friends about their crystal use (i.e., survey item 4). There is no known literature showing evidence that gay and bisexual men can be encouraged by social marketing campaigns to speak with their peers and their partners, yet it has been reported that young gay and bisexual men of color with good sexual communication skills may be less likely to contract HIV (Seal et al., 2000). Better sexual communication skills may be related to HIV protective behaviors for young gay and bisexual men of color. A possible contributing factor to this may be comfort with confronting their friends and partners about the effects of their crystal use. Young men of color need to be involved in activities where they communicate with each other in order to challenge peer norms, in this case, those norms that relate to the acceptance of crystal meth use among peers (Mason, 2003).

On another note, several findings demonstrated that the campaigns may not be as effective with certain types of gay and bisexual men. Men who reported recent use of crystal meth with sex were more likely to report that the campaigns triggered urges to use, an unfortunate unintended result of the campaigns. It is possible that the campaigns were perceived by some gay and bisexual men as trying to instill fear of HIV infection or negative consequences of crystal meth use. If this is the case, then this result provides further evidence that fear-based campaigns are ineffective at preventing negative health behaviors because they run the risk of reinforcing these behaviors and may encourage denial among some members of the intended population of interest (Murphy & Bennett, 2004;Shernoff, 2005). A recent meta-analysis by Albarracin et al. (2005) further supports the idea that fear-based approaches do not seem effective in changing health behaviors.

It was found that men who did not identify themselves as barebackers and men who did not report unprotected sex with HIV serodiscordant partners agreed that they wanted to get help to stop or avoid using crystal (statement 5). Such non-sexual risk taking men may be concerned about the risk of unprotected sex widely associated with crystal. This result can be considered the inverse of rising evidence showing that barebackers and men who have unprotected sex with serodiscordant partners are more likely to use crystal meth (Halkitis, Parsons, & Stirratt, 2001). Health promotion messages that challenge the perceived sexual benefits of crystal meth use and clearly delineate the relationship of crystal use to unprotected sex may be more appropriate for campaigns focusing on MSM in New York City. Gay Men's Health Crisis (GMHC), the first AIDS organization in New York City and the second oldest in United States, supports the idea of the gay community creating messages that provoke its members in thinking differently about the "benefits" of crystal meth use (Osborne, 2004). In addition, Wong et al. (2005) advocates for the integration of messages addressing crystal meth and Viagra® use in syphilis prevention efforts due to evidence showing that simultaneous use may be very dangerous to physical and mental health.

Limitations

Although the men in the sample reported residences in all five boroughs of New York City, this study used a sample of gay men who attended a LGBT-oriented event that required paid admission. Because of this, it is not known how men who did not attend this event reacted to the campaigns described in this article. In addition, statement 4 (". . . want to talk to my friends/partner about their use of crystal") is phrased in such a way that directionality and focus of the conversation is not clear. Thus, we cannot report whether respondents who answered in the affirmative were implying that they wanted to speak to their friends or partners about the negative uses or the positive uses of crystal. It may also be argued that these discussions may be very different with friends and partners.

Implications

The fact that in this study white men, HIV-negative men and men not currently using crystal responded more positively to the campaigns may indicate positive implications for prevention efforts prioritized for this particular segment of gay and bisexual men. Yet, the plight of gay and bisexual men, particularly Black, and Latino men, is duly noted. Recent reports show that, in a study of MSM across five U.S. cities, HIV-positive Black MSM report a staggering disproportionate rate of unrecognized HIV infection (64%) compared to Latino (18%), white (11%), and other race (6%) (CDC, 2005). The same report shows that HIV prevalence was highest among Black MSM (46%) compared to whites (21%) and Latinos (17%). Whether or not these high rates are due in part to crystal meth use is not yet clear. Community organizations in New York City such as Gay Men of African Descent are embarking on educational interventions and political activities to address this issue (Nanín, 2004). Researchers need to collaborate with educators, health department officials, and community members to ensure proper and effective assessment of HIV risk behaviors among MSM, including crystal meth use, in all communities.

Since this study revealed a link between crystal meth use and income as well as area of residence, researchers and service providers may also need to assess the impact of social and contextual factors (e.g., social proximity, social status, sexual and other social relationships) on sexual risk behaviors and drug use in order to develop a more complete picture of this phenomenon. Social network analysis, an increasingly popular academic perspective, uses theoretical models, methods, and techniques from various disciplines (i.e., anthropology, psychology, and sociology) to better understand social relationships and how these relationships impact individual and group behavior (Valente, Gallaher, & Mouttapa, 2004). It may behoove creators of HIV and anti-crystal meth campaigns to link with the social networks of particular sectors of gay and bisexual men (e.g., gay and bisexual men of color) in order to create better health promotion messages based on community norms and to disseminate prevention messages more effectively. Fortunately, anti-crystal meth campaigns for gay and bisexual men of color have recently been developed and implemented by the Lesbian, Gay, Bisexual, and Transgender Community Center, Harlem United, and People of Color in Crisis, Inc., all community-based social service agencies located in New York City.

Lastly, assessments of community reactions to campaigns in other cities dealing with crystal meth and HIV concerns (e.g., Washington, DC; O'Bryan, 2005) need to be implemented. Assessment of current and future public health campaigns will ensure effective and timely approaches are always in existence when necessary. In addition to campaigns that extol the virtues of not using crystal meth at all (i.e., a primary prevention messages), messages that extol the offer to help when one is ready to give up crystal use need to be disseminated (Weinstein, 2005).

Information from this study can assist in the formation of future anti-crystal meth and other health promotion campaigns targeting specific groups of gay/bisexual men. Fisher et al. (1996) acknowledged that HIV-related social marketing to gay and bisexual men is an immense task; campaigns will be more likely to increase motivation for healthy behavior change as long as they incorporate acknowledgment of personal losses, concerns about the epidemic, and conflicting feelings about one's personal decision-making into related health promotion messages. Today, health officials may find it necessary to recognize the many issues related to crystal meth and other drug use use along with other HIV prevention messages.

In addition, knowledge of trends in risk and protective behaviors that exist in this community can effectively guide the formation of public health and social marketing campaigns (Dodds, Mercey, Parry, & Johnson, 2004). Longitudinal studies assessing the prevalence of crystal meth

use among gay and bisexual men and related risk behaviors is absolutely necessary to inform effective educational efforts, including public health campaigns. Increased amounts of timely campaigns can assist in meeting the objectives of reducing health disparities as outlined in Healthy People 2010 (DHHS, 2000). More importantly though, in addition to effective campaigns, holistic anti-crystal meth prevention and treatment programs for gay men on individual, group, and community levels are absolutely necessary to aid in the reduction of these health disparities, especially in relation to HIV/AIDS. To quote Burney (2005), "[c] onfronting the HIV epidemic without an effective anti-crystal meth program is like trying to reduce heart disease without tackling cigarette smoking."

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Figure 1.
Anti-crystal meth campaign ads.

Table 1

Proportions of Affirmative Responses to Campaign Exposure Statements

These ads made me . . .	% agree
1. Think about not starting to use crystal or cutting down on my use	58.4%
2. Glad someone was doing something about crystal use in the gay community	75.9%
3. Want to start using crystal or to use crystal more	11.9%
4. Want to talk to my friends/partner about their use of crystal	38.7%
5. Want to get help to stop using crystal or avoid starting to use	36.1%

Table 2

Group Differences in Reaction to Anti-Crystal Meth Campaigns in New York City

Groups compared	Percentage of agreement	OR	CI
Item 1. Think about not starting to use crystal or cutting down on my use			
White vs. Non-white*	62% vs. 52%	1.49	1.05– 2.11
HIV negative/unknown vs. HIV positive*	60% vs. 47%	1.68	1.04– 2.70
Non-barebacking vs. Barebacking*	60% vs. 43%	2.05	1.16– 3.62
Crystal users: No recent use vs. recent use	63% vs. 52%		
Crystal users: No PnP vs. recent PnP	63% vs. 46%		
Item 2. Glad someone was doing something about crystal use in the gay community			
White vs. Non-white*	81% vs. 68%	2.0	1.35– 2.95
HIV negative/unknown vs. HIV positive*	78% vs. 61%	2.29	1.39– 3.76
Non-barebacking vs. Barebacking*	78% vs. 56%	2.81	1.58– 5.0
Crystal users: No recent use vs. recent use*	89% vs. 68%	3.66	1.36– 9.9
Crystal users: No PnP vs. recent PnP*	88% vs. 64%	4.03	1.59–10.2
Item 3. Want to start using crystal or to use crystal more			
White vs. Non-white	10% vs. 15%		
HIV negative/unknown vs. HIV positive	11% vs. 15%		
Non-barebacking vs. Barebacking	11% vs. 13%		
Crystal users: No recent use vs. recent use	10% vs. 23%		
Crystal users: No PnP vs. recent PnP*	11% vs. 27%	2.95	1.09– 7.98
Item 4. Want to talk to my friends/partner about their use of crystal			
White vs. Non-white*	35% vs. 45%	1.49	1.05– 2.11
HIV negative/unknown vs. HIV positive	39% vs. 36%		
Non-barebacking vs. Barebacking	39% vs. 31%		
Crystal users: No recent use vs. recent use	48% vs. 44%		
Crystal users: No PnP vs. recent PnP	49% vs. 40%		
Item 5. Want to get help to stop using crystal or avoid starting to use			
White vs. Non-white	35% vs. 39%		
HIV negative/unknown vs. HIV positive	37% vs. 33%		
Non-barebacking vs. Barebacking*	37% vs. 24%	1.91	1.01– 3.65
Crystal users: No recent use vs. recent use	40% vs. 36%		
Crystal users: No PnP vs. recent PnP	40% vs. 35%		

* $p < .05$

Table 3

Participant Demographics

Sample characteristics	%	*n*
Race/Ethnicity		
African-American	9.1	88
European/White	61.6	598
Latino	16.4	159
Asian/Pacific Islander	7.5	73
Other	5.5	53
Age		
18–30	26.9	261
31–40	33.6	326
41–49	25.4	247
50 and over	14.1	137
HIV status		
Positive	13.4	130
Negative	78.8	765
Unreported	7.8	76
Education (*n* = 964)		
Less than Bachelor's degree	33.0	318
Bachelor's degree	32.1	309
More than Bachelor's degree	35.0	337
Relationship status		
Single	57.5	558
Partnered, non-monogamous	20.1	195
Partnered, monogamous	22.5	218
Income (n = 954)		
Less than 20K	17.4	166
20–40K	20.3	194
40–60K	24.9	238
60–80K	14.8	141
More than 80K	22.5	215