



# Substance misuse services for men who have sex with men involved in chemsex

This briefing for commissioners and providers of drug and alcohol services highlights issues relating to men who have sexual contact with other men (MSM)<sup>a</sup> involved in chemsex. It contains background information, recent data, prompts for local areas and services, and case studies.

Chemsex is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. Chemsex commonly involves crystal methamphetamine, GHB/GBL and mephedrone, and sometimes injecting these drugs (also known as slamming). These practices can have an adverse impact on the health and wellbeing of MSM.

The main focus of this briefing is chemsex among MSM. However, much of the good practice covered also applies to wider MSM and lesbian, gay, bisexual and transgender (LGBT) populations. Furthermore, not all MSM who need treatment for other alcohol and drug problems participate in chemsex. Detailed guidance and audit tools for commissioning and providing drug and alcohol treatment for LGBT communities are published by London Friend,<sup>1</sup> commissioned by the Department of Health. This briefing is a component of PHE's broader work on LGBT health and wellbeing, including the LGBT public health outcomes framework<sup>2</sup> and an action plan to tackle health inequalities for MSM.<sup>3,4</sup>

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<sup>a</sup> MSM: 'men who have sexual contact with other men' is the term this document uses to identify most clearly the population of interest because it describes sexual behaviour, rather than sexual identity. We acknowledge that it is not a term appropriate to use more broadly when discussing issues of diversity relating to the male gay community or to the lesbian, bisexual and trans communities. However, we believe its use is helpful in this context in ensuring we are as inclusive as possible in covering the topic of chemsex. At times, we use other terminology, such as LGBT when discussing research or data issues, when appropriate.

## Background

### Key points

Surveys indicate that compared to the average for the adult population as a whole, a higher proportion of MSM drink alcohol and use drugs.<sup>5</sup> As well as the effects of problematic alcohol and drug use, the recent emergence of chemsex can pose additional hazards both to the individual involved and public health. Where drug use takes place in a sexual context the risk of transmission of HIV, hepatitis B and C and other sexually transmitted infections (STIs) increases.<sup>6,7</sup>

The following are key points relating to MSM, drug treatment and chemsex:

- most MSM do not use drugs,<sup>5</sup> not all MSM who use drugs use them in a sexual setting, and not all MSM who use drugs in a sexual setting do so in a problematic way
- MSM may not engage with some healthcare services because they fear experiencing stigma or they may feel that service provision is not equipped to help them
- MSM accessing drug treatment services may benefit from talking about specific sexual practices (for example, sex with multiple partners or fisting) but many are concerned that this can cause staff to be unsympathetic to their needs
- MSM engaged in chemsex may feel that sexual health services are more likely to be empathetic and knowledgeable compared to drug treatment services
- some MSM who present to services and require support may not consider that they have a drug problem or may not present the problem in typical substance misuse terms – they may say they have been “partying too hard” or “craving a lot of sex”
- MSM engaged in chemsex can be at increased risk of infection from blood-borne viruses,<sup>8,9</sup> STIs<sup>10</sup> and other diseases such as Shigella infection<sup>11</sup>
- the needs of MSM using recreational drugs such as cocaine, mephedrone or GHB in social clubbing environments may be different from those using drugs in a sexual setting – although both groups may be reluctant to engage with traditional substance misuse services and will require services relevant to their needs<sup>12</sup>
- MSM are diverse group, with men from black, asian and minority ethnic groups (BAME) having different needs

- MSM who use drugs as part of chemsex are often in full-time employment, use drugs intermittently and often generally function well in life
- individuals who use drugs occasionally may be unaware of safer injecting practices and the availability of services, equipment and advice that can reduce risks
- patterns of alcohol and drug use and chemsex are often related to broader wellbeing issues or problems

### Data – what do we know?

Although published data is limited, a small number of surveys,<sup>13</sup> along with PHE and Home Office data, give us some insight into the level of substance use among MSM.

Data from the Crime Survey for England and Wales for the three-year period from 2011-12 to 2013-14<sup>5</sup> showed that reported drug use was around three times higher among gay and bisexual men than among heterosexual men. Reported use of stimulants was around five times higher, with methamphetamine use around 15 times higher. The use of alkyl nitrites was around 19 times higher.

The Part of the Picture research project<sup>14</sup> found that just over one quarter of self-defined lesbian, gay or bisexual people in the study met the criteria for substance dependence.<sup>b</sup>

A 2008 analysis of research studies<sup>15</sup> reported that lesbian, gay and bisexual people were at higher risk of substance misuse and dependence than heterosexual participants, with 50% higher rates of alcohol dependence seen in gay, bisexual and MSM groups in these studies.

The National Drug Treatment Monitoring System (NDTMS) collects detailed information on individuals in structured drug and alcohol treatment in England including information on sexuality.<sup>c</sup>

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<sup>b</sup> To assess substance use and dependency, Part of the Picture applied the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) and the International Classification of Diseases (ICD-10) compatible screening questionnaire for harmful substance use.

<sup>c</sup> Completion of the sexuality data field in NDTMS is significantly varied across local areas, with national compliance at 68%. This data is likely to under-report the actual numbers in treatment.

PHE encourages data collection on sexuality through NDTMS and changes to forthcoming versions of the dataset will provide a more complete picture of the numbers of LGBT people presenting to specialist drug and alcohol treatment services.

NDTMS data shows that 959 self-reported gay or bisexual men started drug treatment in 2013-14 (accounting for 3% of all men who started treatment in the year). Forty-eight per cent of them, or 464 men, starting drug treatment lived in London.

The drug-taking profile of this group differed markedly to that of men who self-reported as heterosexual. A greater proportion of gay or bisexual men presented to treatment with problematic amphetamine use (32% compared to 7% of heterosexual men), and GBL use (16% compared to 0.1% of heterosexual men). Problematic use of heroin (29%) and crack cocaine (19%) was much less prevalent among gay or bisexual men presenting to treatment.

Gay or bisexual men in treatment for non-opiate drugs were more likely to inject (16%) compared to heterosexual men (3%), which may reflect the practice of slamming (injecting mephedrone or crystal methamphetamine). This should be seen within the context that rates for injecting opiates were practically the same for gay or bisexual men as for heterosexual men.

### Prompts for commissioners of drug and alcohol services

The following prompts support commissioners of drug and alcohol services meet the needs of MSM who participate in chemsex. Responses to these questions may highlight a gap in provision, but might also indicate there is no relevant local need.

*Understand the needs of the local MSM population and commission appropriate services*

1. Have you assessed the extent of the local MSM population and associated patterns of drug use, including rates of injecting and rates of club drug and new psychoactive substances (NPS) use, and have you used this intelligence to inform commissioning plans?
2. Is relevant data and intelligence on MSM and associated drug use shared with all appropriate commissioned services in your local area?
3. Are you working with local services and LBGT charities to develop and improve data collection?
4. Are you working with with sexual health commissioners on developing joint strategic commissioning plans and commissioning integrated care pathways where suitable and beneficial to your local substance-using MSM population?
5. Do you include service specifications in your contracts that require providers to demonstrate broader LGBT inclusion?

6. Have you considered commissioning specific targeted services where appropriate and in line with local need?
7. Do you ensure that providers monitor sexual orientation, gender identity, race and ethnicity for all service users and use this information to show compliance with public sector duties in the Equality Act?<sup>16</sup>
8. If local need is assessed as low, are pathways in place to ensure that when need does emerge it can be met quickly (ie, in another local area or through your own services)?
9. Do you use information on national trends and local intelligence to regularly assess and respond to changes in patterns of drug use among MSM, and is that intelligence shared with local authority decision makers to inform broader local strategic planning?
10. Do you explore any evidence of low service use by MSM with other strategic stakeholders – for example, some preferring to access sexual health services but not drug and alcohol services – and does this inform local planning?
11. Have you made appropriate links with local clinical commissioning groups and health and wellbeing boards, and do you work with them in their planning for the broader needs of MSM?

#### **Guy's and St Thomas' NHS Foundation Trust (Burrell Street Clinic)**

The Burrell Street Sexual Health Clinic opened in 2012. Increasing numbers of MSM were presenting with a history of using drugs during episodes of unprotected sex. During 2013 the clinic began to see MSM who reported injecting mephedrone and methamphetamine.

Working with local drugs services, the clinic developed 'slamming kits'. The kits ensure that men who choose to inject are doing so as safely as possible. The kits contain colour-coded needles (lessening the chance of accidentally using the wrong needle) and syringes showing measures for GBL (lessening the chance of overdose).

Distribution of the kits has encouraged MSM to use other counselling and sexual health screening services at the clinic. This has helped to diagnose previously undiagnosed HIV infections and STIs among this group.

#### *Support the development of local services to meet need*

1. Where it is not feasible or practical to offer dedicated LGBT-specific services, are you supporting developments and raising awareness within existing services to ensure provision can meet the needs of this group, perhaps

through partnership working with other services with good MSM knowledge and competence?

2. Are you establishing partnerships between alcohol and drug services and sexual health services to ensure an integrated approach to care, including training existing staff groups to improve their knowledge and awareness of the substance misuse and sexual health issues commonly faced by MSM?
3. Is the commissioning of substance misuse and sexual health services aligned?
4. Have you explored the potential benefits of locating relevant and targeted drugs service provision (for example, needle and syringe programmes) in sexual health services or other relevant services?
5. Are you considering how to engage with MSM in new settings, for example, through sexual health services or venues such as gay bars and saunas, and through the gay press?
6. Are you developing integrated care pathways across relevant services, for example, between substance misuse and sexual health services?
7. Are you working with the voluntary and community sector to enhance responsive local systems, including any peer support and mutual aid groups?
8. Do initiatives include reaching out to all sections of the community, including black and minority ethnic (BAME) MSM?
9. Do your service contracts with providers stipulate staff development in relation to meeting the needs of specific populations and patterns of drug use, including supporting them to be more competent and confident in discussing chemsex-specific issues with MSM?
10. Are your contracts responsive to changes in service user profiles, including among local LGBT and BAME communities?

**Chelsea and Westminster Hospital NHS Foundation Trust (Dean Street Clinic)**

Due to the large numbers of chemsex presentations, the Dean Street Sexual Health Clinic employs a dedicated drugs worker. Workshops and support for MSM include: groups that explore issues such as safely using online sex apps and sites; a group that examines 'sober-sex'; a needle exchange facility; safer injecting support; and information that specifically addresses methamphetamine and mephedrone injecting.

Dean Street also carries out extensive partnership work with local drug services and local gay charities.

## Prompts for providers of drug and alcohol services

These prompts help providers meet the needs of MSM who present to services and may have problems related to chemsex. Responses may highlight a gap in provision or might indicate that there is no relevant local need.

### *Understand and meet local need*

1. Are you aware of the patterns of drug use among MSM in your local area, for example, rates of injecting drug use, club drug and NPS use?
2. Are the services you provide accessible? For example, are they available outside normal working hours and are services, satellite services or outreach services operating in targeted areas or other services?
3. Do services work jointly with sexual health services, particularly in relation to developing referral pathways?
4. Do you provide needle and syringe programmes in sexual health services?
5. Are your services made aware of current surveys and information resources, such as the National Gay Men's Sex Survey<sup>17</sup> or the Part of the Picture<sup>14</sup> report, which could give insight into MSM and drug use in your area?

### **Central and North West London NHS Foundation Trust (Club Drug Clinic)**

The CNWL Club Drug Clinic provides a service tailored to the needs of club drug users. The clinic offers medically assisted withdrawal from substances including GHB/GBL. It also prescribes medication to help manage the side effects of coming off stimulants such as mephedrone and other substances.

Specialist addiction doctors and psychologists, nurses and counsellors provide advice and support, as do peer mentors who have experienced and overcome similar problems. On-site sexual health screening and support is available, along with liaison and referral for mental and physical health problems (including bladder and kidney problems, and HIV and other blood-borne viruses).

Recognising the different needs within this client group, the clinic works in partnership with London Friend's LGBT drug and alcohol service, Antidote.

*Recognise and respond appropriately to individual need*

1. Where services are provided as part of a mainstream drug or alcohol treatment service, are providers confident that they are, or can be, responsive to the specific needs of MSM, including addressing sexual and mental health problems, issues of personal stigma and different patterns of drug use?
2. Are your services aware that some MSM may not self-assess their drug use as problematic and are staff skilled at supporting problem recognition in an appropriate way?
3. Does your service seek feedback from specific groups, including MSM, so it can develop and adapt to be relevant and accessible?
4. Are staff in your needle and syringe programmes aware that different advice and equipment may be required from that given to opiate injectors (for example, 'slamming packs' containing coloured needles and syringes for measuring GBL)?
5. Are staff comfortable discussing service users' sexual practices that may be linked with drug use?
6. If MSM have previously had negative experiences in drug and alcohol treatment services are staff supported and supervised to explore these issues and develop their practice and services?
7. Do staff receive training and support to develop competencies in assessing, treating and referring MSM clients in a culturally sensitive manner?
  - the US Substance Abuse and Mental Health Services Administration (SAMHSA) has developed training curricula for behavioural health and primary care practitioners to help them assess, treat, and refer LGBT clients in a culturally sensitive manner,<sup>18</sup> which may be of interest to those responsible for developing training for staff in the UK
  - the Pride in Practice quality assurance service,<sup>19</sup> endorsed by the Royal College of General Practitioners, is a support package that enables practices to effectively meet the needs of their lesbian, gay and bisexual patients

**John** is a 27-year-old gay man in full-time employment and living with his partner of three years. He presented to CNWL's Club Drugs Clinic for support following a short stay in hospital after he was found wandering the streets experiencing drug-induced psychosis and paranoia (hearing voices, fearing he was being watched and controlled by others) and was unable to work out how to get home. John had spent the weekend at different chemsex parties, smoking crystal methamphetamine and taking GBL, and engaging in unprotected sex. He had not slept for three nights and feared losing his job having disclosed his drug use to his line manager on the telephone while intoxicated. He was recently diagnosed HIV positive with an undetectable viral load and was not on medication.

The following treatment plan was initiated:

- general assessment (including risk assessment)
- medical assessment with a psychiatrist
- prescribing for current symptoms and liaison with his GP in relation to any ongoing prescribing
- allocation to a high complexity pathway, including one-to-one keyworking for up to six months with an LGBT keyworker from Antidote (for motivational interviewing, harm reduction advice, relapse prevention advice), Club Drugs Clinic nurse liaison and group work as appropriate
- referral and liaison with the local sexual health service to arrange a sexual health screen to ensure a follow-up to the recent HIV diagnosis is agreed
- additional support from Antidote weekly drop-in sessions
- offer of support to John's partner and sessions with a family therapist (with option for joint sessions should the couple wish to discuss managing the situation with the therapist)
- once use is stabilised, a post-treatment referral to London Friend for counselling to address underlying issues

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