Sexualised drug use: the national picture

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Overview

What is chemsex?
What is the prevalence of chemsex?
Why does it matter?
Where does it occur?
Chemsex interventions
Gaps in the evidence
PHE action plan
What is ‘chemsex’?

“Use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience.”

- Key drugs mephedrone, GHB/GBL, and crystal meth (taken IV ‘slamming’, snorted, and orally)

- Drugs often used in combination, facilitating sex sessions over several days and with multiple partners

PHE: Substance Misuse services for men who have sex with men involved in chemsex. Briefing for commissioners and providers of drug and alcohol services.
Sexualised drug use: the national picture


What does chemsex do?

Mild anaesthetic

Psychological disinhibition: reduced inhibitions

Better sex, increased pleasure

Increased stamina: Longer sex sessions, multiple partners

Help confidence

Causal pathway

Interactions
What is the prevalence of chemsex?

Prevalence estimates from clinic based surveys vary:

**HIV positive MSM**
- 7% recreational drug use in past 3 months (ASTRA 2014)
- 29% engaged in chemsex in last year, 10% in slamsex (Positive Voices 2015)

**HIV negative MSM**
- 12% drug use in last 3 months, 5% during last time sex (GUMCAD 2016)
- 54% engaged in chemsex in last 3 months (PROUD 2016)
Why does it matter?

High risk sexual behaviours
increased partner number, UAI, serosorting

STIs
Bacterial rectal STIs, HIV, Hepatitis C

Delayed PEPSE
Decreased ARV adherence

Mental health
Overdose, dependence, withdrawal, drug induced psychosis,

Health, wealth, crime

Where is chemsex occurring?

Frequency of chemsex consultations in GUM clinics by urban-rural setting (n=152) (Wiggins 2016)
Chemsex interventions

- No gold standard

- **Very little evidence**: Systematic review of bio-behavioural interventions (MacDonald BHIVA 2017): 6967 papers identified, 5 met inclusion criteria including 2 RCTs.

- Integrated sexual health and drug & alcohol service approach


- http://www.chemsexsupport.com/for-professionals
Gaps in the evidence

- Lack of consensus on chemsex definition
- No gold-standard intervention or care pathways
- Lack of event-level data
- Lack of national surveillance data
- No longitudinal data of associations between chemsex and STIs/HIV/HCV
- Associations with broader health and mental health harms
- Causal pathways
- Effective prevention interventions
### Action

| **Collaborative working** with PHE Centres and Local Authorities | • Roundtable event  
• Toolkit for centre use |
|---|---|
| Evidence and data to **support commissioning** | • Resource packages  
• Briefing notes  
• JSNA data packs  
• Slide sets/infographics |
| **Promote awareness** of ‘chemsex’ and sexualised drug use | • Health Matters Resources  
• Publications/conferences |
| **Strengthen data collection in established surveillance systems** | • GUMCAD/UAM/NDTMS |
| **Support new data collection** | • BASHH/PHE survey in GUM clinics  
• Support local/regional surveys |
Briefings and guidance

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) involved in chemsex. It contains background information, recent data, priorities 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 methadone, and sometimes injecting these drugs (also known as stemming). 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 Ireland, 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 and an action plan to tackle health inequalities for MSM.

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 behavior, rather than sexual identity. This is important because the term ‘gay’ often includes other sexual identities and can be seen by some people as a pejorative term. At the same time, using terms such as ‘LGBT’ or ‘Lesbian, Gay, Bisexual and Transgender’ is problematic as it can be difficult to identify individuals who self-identify in that way. In this briefing and the context in which it is being used, we are as inclusive as possible in covering the topic of chemsex. At times, we use some terminology, such as LGBT when discussing research or data sources, when appropriate.
Conclusions

- Chemsex is an important public health issue, although reported by a minority of MSM
- Patients reporting chemsex are presenting to GUM clinics and D&A services in all areas of the UK
- Little evidence for best interventions
- Integrated sexual health and drug & alcohol service approach
- PHE Action Plan to provide evidence, collect data (new & enhanced surveillance), improve awareness
Acknowledgements

- PHE chemsex working group
- Nigel Field
- PHE/BASHH Chemsex survey: Helen Wiggins, Helen Mebrahtu, Ann Sullivan and Gwenda Hughes
- PHE GUMCADv3 pilot: John Were, Hamish Mohammed, and Gwenda Hughes
Thank you

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Key points (on MSM and chemsex) for services

• MSM are a diverse group
• most MSM do not use drugs
• MSM may not engage because of stigma
• MSM accessing drug treatment services may benefit from talking about specific sexual practices
• MSM may prefer sexual health services in the first instance
• some MSM may not recognise a drug problem
• MSM engaged in chemsex are at increased risk of BBVs and other infections
Key points (on MSM and chemsex) for services (continued)

• MSM who use drugs as part of chemsex often don’t show signs of not coping

• individuals who use drugs occasionally may be unaware of safer injecting practices

• patterns of alcohol and drug use and chemsex are often related to broader wellbeing issues or problems
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<th>Actions</th>
<th>Key Deliverables</th>
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<td>1. Improve collaborative working and engagement with PHE Centres and Local Authorities</td>
<td>1.1 Convene roundtable event with the aim to</td>
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<td>• Present currently available data on sexualised drug use and ‘chemsex’</td>
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<td>• Present examples of local responses to ‘chemsex’ and sexualised drug use</td>
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<td>• Scope and co-produce a workplan with commissioners, third sector organisations, sexual health and drug and alcohol teams</td>
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<td>• Coordinate and support local guidance</td>
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<td>2. Provide evidence and data to support commissioning and the monitoring of outcomes</td>
<td>2.1 Development of an internal toolkit for Centre teams and localised ‘chemsex’ resource packages, including:</td>
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<td>• ‘chemsex’ guidance</td>
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<td>• examples of locally available data</td>
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<td>• examples of how local data can be used to inform commissioning decisions</td>
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<td>• examples of questions and prompts for joint strategic needs assessment (JSNA)</td>
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<td>• examples of the evolution of good practice for a sample of Local Authority areas and CCGs with broad representation</td>
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<td>2.2 Update the 2016 briefing note for drug service commissioners, and extend this briefing note to sexual health commissioners.</td>
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<td>2.3 Include data items, as they become available, in JSNA data packs and LASERs to support commissioning and encourage collaboration between sexual health and drug treatment commissioners.</td>
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<td>2.4 Development and provision of slide sets and infographics, including a ‘why invest’ model to support local guidance.</td>
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<td>3. Promote awareness of ‘chemsex’ and sexualised drug use with a wider audience</td>
<td>3.1 Development of a PHE ‘chemsex and sexualised drug use’ communications plan</td>
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<td>3.2 Publish Health Matters Resources including:</td>
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<td>• Infographics</td>
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<td>• Blog</td>
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| 4. | Strengthen data collection in established surveillance systems to include information on sexualised drug use/chemsex | 4.1 Work with GUMCAD steering group to propose questions on sexualised drug use for inclusion in national genitourinary medicine surveillance (GUMCAD v3) to provide an estimate of national prevalence, trends over time, and associations with sexual health harm  
4.2 Propose inclusion of question on chemsex related drugs in the national Unlinked Anonymised Monitoring (UAM) Survey to monitor trends in injection of chemsex related drugs  
4.3 Collect data on sexual orientation in national drug treatment data (NDTMS) to better understand patterns of use, need and outcomes. |
| 5. | Support data collection on sexualised drug use and associated health harms | 5.1 Development and roll out of a BASHH/PHE survey in GUM clinics in England and Scotland  
5.2 Development and roll out of STI&BBV NIHR HPRU led clinic-based survey of MSM and drug use  
5.3 Provide scientific support to local and regional chemsex surveys (e.g. clinic based survey in North East England) |
HIV positive MSM: Positive Voices Study (Purfall CROI 2015)

Chemsex associated with increased risk of being diagnosed with:
• Any STI (AOR 3.42)
• Gonorrhoea (AOR 2.76)
• Hepatitis C (AOR 6.26)

Slamsex associated with increased risk of being diagnosed with:
• Any STI: AOR 3.85
• Chlamydia: AOR 3.09
• Hepatitis C: AOR 9.12

Adjusted odds ratios comparing the association between chemsex, slamsex, and self reported STI diagnoses
Chemsex and risk behaviour

PROUD study (HIV negative MSM)

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<th>Overall number (N=424)</th>
<th>Chemsex users (N=222)</th>
<th>P value</th>
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<td>Injecting drugs*</td>
<td>80 (19%)</td>
<td>77 (35%)</td>
<td>&lt;0.001</td>
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<td>Group sex*</td>
<td>286 (67%)</td>
<td>182 (82%)</td>
<td>&lt;0.001</td>
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<td>Sex toys*</td>
<td>189 (46%)</td>
<td>126 (57%)</td>
<td>&lt;0.001</td>
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<td>Fisting*</td>
<td>116 (27%)</td>
<td>82 (37%)</td>
<td>&lt;0.001</td>
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<td>UAI since last visit*</td>
<td>418 (99%)</td>
<td>222 (100%)</td>
<td>0.010</td>
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<td>Median # condomless anal sex partners in past 30 days (IQR)</td>
<td>2 (1,5)</td>
<td>3 (1,6)</td>
<td>&lt;0.001</td>
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*In last 3 months
HIV positive MSM (Positive Voices 2014)

Chemsex associated with:
- increased UAI
- serodiscordant UAI
- serodiscordant UAI with detectable VL
- increased number of partners in the past year

Adjusted OR comparing the association between chemsex, slamsex, and risk behaviours (Pufall CROI 2015)