Sexualised drug use by MSM: background, current status and response

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Background

Substance misuse and HIV have never been strangers to each other: the injecting use of opiates has always presented a considerable BBV (blood-borne virus) threat to injecting drug users. Health services (particularly sexual health and drug support services) have demonstrated excellent awareness and practice in responding to these risks, constantly re-thinking and improving needle-exchange services and finding ways to better understand and engage this patient group. Additionally, the chaotic sexual behaviours associated with homelessness, sex working and drug addiction are well understood, with workers being highly skilled in HIV management and prevention messages for this vulnerable group.

Recent developments

The last 5 years, however, have seen emerging trends in substance misuse that are not only challenging HIV and drug services, but may also be responsible for the increased numbers of HIV transmissions reported lately – namely, the rise observed by drug support services and sexual health clinics in the sexualised use of crystal methamphetamine, mephedrone and GHB/GBL by MSM populations. One service in particular, the Antidote* substance misuse service, has been overwhelmed by gay men presenting with complicated sexual health consequences from the sexualised use of these drugs. Crystal methamphetamine, mephedrone and GHB/GBL have all become (arguably) a normalised part of sexual recreation amongst gay men in London, and all have the effect of increasing libido and confidence, while decreasing sexual inhibition (Table 1).

This is further enabled by the proliferation of online sites and mobile apps used by gay men to find sex partners, many of which are used with search tools and code words/phrases to help site visitors find 'chem-sex'. While under the influence of these powerful drugs, many users find that any boundaries they may have had around their own sexual activity or adherence to ART (antiretroviral therapy) become inconsequential as chaotic sexual marathons of up to 3 days with multiple partners become a drug-induced priority.

Data sources

I have been observing the epidemiology of these trends over the last 7 years, from my vantage point of managing Antidote, the UK's only lesbian, gay, bisexual and transgender (LGBT) drug and alcohol support service, based in London. Antidote is currently part of the London LGBT health and wellbeing charity, London Friend, and attracts many MSM who may be reluctant to present at statutory or NHS services [1].

Much of the evidence in this paper is based on currently unpublished data monitored at Antidote. Notably, few sexual health or HIV clinics monitor drug use in a way that reflects these trends, instead focusing on injecting opiate use (fewer than 2% of LGBT people presenting at the Antidote service use heroin or crack cocaine, preferring instead to use drugs that serve the context of clubbing and sex). The focus on heroin and crack cocaine use by statutory drug services is associated with classification policy dictated by the National Treatment Agency, whereby heroin, crack cocaine and alcohol are classed under PDU (problematic drug use), and everything else as 'non-problematic'. Many of these services are adapting to these changing trends (as is government drugs policy), with varied success; but, as with all new trends, changes are often reflected first in smaller communities before spreading to the wider population, and this is the reason for a current lack of data from statutory services.

Beyond the data monitored at the Antidote service, we do at least know that:

- there are 25,000 fewer heroin/crack addicts in the UK population since 2005 [2], suggesting that either fewer people are taking these drugs, or that users are switching to new drugs and being less accurately monitored;
- 300,000 people in the UK report having used mephedrone in the last year [3] (as opposed to 0 in 2006);
- gay and bisexual men in the UK used five times more drugs than their heterosexual counterparts in 2010 [1], compared to seven times more in 2012 [4].

Old habits

Seven years back HIV was, unsurprisingly, an issue for MSM, though not directly as a result of drug use.

Table 1: Popular 'chem-sex' drugs: summary

Known as / abbreviation	Full name	Usage
Crystal meth, Tina	Crystal methamphetamine	Smoked or injected
GBL, G	Gamma butyrolactone	Ingested orally
GHB, G	Gamma hydroxybutyrate	Ingested orally
Miauw miauw, drone, MCAT	Mephedrone	Snorted or injected
IDU	Injecting drug use/r	
PDU	Problematic drug use/r	

The most commonly used drugs by gay men in 2005 were ecstasy and cocaine. While many clubbers from that time might have cited hugging a new friend in a nightclub for too long, or entertaining a stranger with one's life story, as the most harmful effects of ecstasy use, it was not contributing in a significant way to HIV transmission. Equally, chatting overenthusiastically at a dinner party, or enjoying some clumsy, twitchy sex may have been a reason to address one's cocaine use, but it would not have been responsible for any significant increase in GUM presentations. However, the data below reflect the dramatic change in MSM drug use over the last 6 years, as seen by the Antidote service, which has contact with over 8,000 LGBT individuals per year, and annually puts 800 people through structured treatment (95% being MSM).

- In 2005, crystal meth, mephedrone and GHB/GBL were responsible for only 3% of all presentations (the remaining 97% relating mostly to alcohol, cocaine and marijuana; and to a lesser extent, ecstasy, heroin and crack cocaine).
- In 2012, crystal meth, mephedrone and GHB/GBL were responsible for 85% of all Antidote presentations.
- In 2005, referrals from sexual health services accounted for 8% of our Antidote presentations.
- In 2012, the same referral sources were accounting for 63% of Antidote presentations, a direct reflection of the increased sexual health consequences of these drugs.

Current behaviours

Leap to 2013, where the most commonly used drugs by gay men in London are crystal methamphetamine, known colloquially as 'Tina', mephedrone (referred to in the press as 'miauw miauw') and GHB/GBL (casually referred to simply as 'G'); all are used to varying degrees in a sexual context, with some alarming sexual health consequences.

Data from Antidote presentations are as follows:

- 99% of crystal meth users are using the drug solely to facilitate sex;
- 75% of mephedrone users are using the drug solely to facilitate sex;
- 85% of GBL users report using the drug to facilitate sex;
- 80% of crystal meth and mephedrone users are now injecting in a sexual context (a rise from 20% in 2011);
- 70% report having shared needles to inject their drugs.

75% of these drug users are HIV positive, and of these:

- 60% report a failure to adhere to an ART therapy regime while under the influence of drugs;
- 90% attribute their HIV (or hepatitis C) diagnosis to drug or alcohol use.

In comparison, of Antidote's HIV-negative clients:

- over 50% have had one or more courses of PEP (post-exposure prophylaxis) in the last year (some reporting as many as 10 courses).

Anecdotally:

- most report preferring to use 'bareback' sites to find sex online; usually because of the increased probability of finding chem-sex partners or drug availability on these sites, as well as a desire not to discuss or disclose HIV status while under the influence of drugs;
- most report an average of between five and ten partners per drug-using episode.

The obvious and alarming conclusion to be drawn from this data is that there are large numbers of HIV-positive men, more virulent than they may know due to poor adherence, each having unprotected sex with approximately ten men on most weekends, while under the influence of powerful drugs. This behaviour will be responsible for numerous (and costly) PEP courses, increased HIV diagnoses, as well as other sexually transmitted infections that may make HIV-negative people more vulnerable to HIV, or complicate the health of HIV-positive men.

Obstacles and disincentives

In a gay media climate of HIV prevention messages, there can be a *stigma* that prevents this patient group from accessing support or disclosing risky sex or drug use. There is also a *sense of shame* experienced by many Antidote clients about their behaviour, whether conscious or internalised. They can experience *confusion* as to why they are driven to such sexual extremes while 'high', or compelled to repeat this behaviour despite accessing support. This client group can also perceive *judgment* of such behaviour, real or imagined, by health services [1]. Additionally, there is much *ignorance*

Case study

To illustrate the context and motivations for this behaviour, the following anonymised case study is typical of the client group presenting at the Antidote service.

PJ is a 35-year-old gay man, 7 years HIV positive (asymptomatic) and taking antiretroviral therapy (ART). He first tried smoking crystal meth 5 years ago when a relationship failed, and began using online 'hookup' sites more actively. He found he could have more confident sex which he describes as 'porn-star sex', which would last an entire weekend and gave him a sense of inclusion, satisfaction and sexiness he'd never felt before. He visited saunas and joined sex parties more confidently and frequently, and enjoyed a playground where HIV was never discussed (which he described as 'a relief'); where it was also assumed that all players were HIV positive, and where condoms were rarely used. He soon began missing days at work, was often exhausted and unmotivated and found that his non-sexual social life was diminishing.

Having been made redundant 4 years earlier, his use increased and he was introduced to injecting. He preferred to take his chances sharing needles than getting his own following a visit to a statutory drug service where, despite having disclosed his crystal meth use, he was given injecting equipment and information relevant to heroin injecting (crystal meth injecting practice being quite different). Though he did not disclose his drug use to his HIV healthcare team, he was prescribed anti-depressants which he claimed helped him to manage his comedowns.

PJ was referred to the Antidote service 8 months ago following an A&E admission with drug-induced psychosis (a common side effect of crystal meth when used without sleep for 2 or more days). He had claimed there was a Satanic cult of crystal meth users at a sex party that had forced him to perform dangerous sex and share blood through syringes and had generally terrorised him. (He later acknowledged that this was transference and that internalised shame of his own drug-induced sexual desires had manifested those beliefs.)

During assessment, PJ disclosed he had not had sober sex in 4 years, and had no desire to do so, claiming it was 'boring compared to chem-sex'. Though ambivalent about making changes to his drug use, he did want to learn how to avoid psychotic episodes and other unpleasant side effects; he was also pleased to access accurate injecting information/equipment, and to discuss his use with an LGBT worker, which he found less shaming than a mainstream clinical setting. He committed to six structured sessions to discuss these issues.

Motivational interviewing techniques were employed to help PJ reflect on the possible benefits of sober sex and intimacy, and to familiarise him with any fears or issues that might be driving his sexual behaviour. The same techniques helped PJ to address a fear of disclosing his status and to acquire the communication skills to do so. He learned to negotiate the risks of drug use and condomless sex so he was more enabled and informed to make safer, more esteemed choices. Work was done to help PJ apply learned boundaries to his online profiles and communication. After 12 weeks of structured sessions (that involved two relapses), PJ was referred to a counsellor to address the impact of his HIV diagnosis on his failed relationship, intimacy issues and post-trauma management from 5 years of self-harm and isolation through drug use.

about newer drug trends from non-LGBT drug services, or the sexual context may be *challenging* for some non-LGBT drugs-workers [1].

There is also a greater sense of *ambivalence towards change* where these drugs are concerned, compared to the traditional heroin or crack. Even the most reluctant-to-change opiate user will have an understanding of the chaos his/her drug use causes, an understanding that any sense of a stable life means abstaining from using; they may even be more willing to identify as an 'addict'. In contrast, crystal meth, mephedrone and GHB/GBL are often a normal part of this client group's sex lives, weekends and general lifestyle, *considered acceptable and normal* as a form of weekend recreation. Thus traditional models of treatment that are abstinence-focused become unattractive and unsuccessful. Advertising campaigns, harm-reduction messages or assessments that use *traditional terminology* such as 'addict', 'addiction', 'substance *mis*use' (as opposed to substance *use*) can be the very things that prevent people from accessing our services, or disclosing fully when they do. A standard question on a GUM assessment that asks a new patient to identify as an injecting drug user may get an honest response from an opiate injector, but it will only elicit *defensive*, *dishonest responses* from a recreational crystal meth injector, who *does not identify* as such.

Response to change

These trends have transformed the Antidote service from, some would say, a fluffy, 'TLC' kind of service, to one of urgent interventions with adapted/tailored

new treatments, a robust training/education programme and, most importantly, newly formed relationships with NHS sexual health/HIV services. We very quickly learned that Antidote could not exist in this changing climate as a silo, and invited ourselves to as many academic and clinic meetings as we were welcome, to share knowledge and experience, improve referral pathways and (frankly) to seek as much support around these alarming trends as was available to us.

One of the very first discoveries we made was that the 800 or so people accessing support at Antidote each year was just the smaller underbelly of a larger group of drug-using MSM who, though not ready to seek help from a drugs service, were accessing sexual health clinics in large numbers, with frequent STIs or PEP requests as a result of chem-sex.

These clinics were not formally monitoring drug use among these patients; certainly, at least, not in a way that differentiated between a heterosexual opiate injector and a gay man using crystal meth or GHB/GBL for sex. Some informal needs assessments conducted at the busiest London GU/HIV clinics found anecdotal reports of very large numbers of patients disclosing 'party drug' use. It found many nurses and sexual health advisors feeling overwhelmed and under-informed, or learning very quickly and having to think creatively when faced with the chaotic sex lives of their patients, some of whom were presenting – four to six times a month, in various states of intoxication – with STIs, requesting PEP, or alarmed at having missed their HIV medications while on a 3-day 'bender'. Some sexual health clinics also found that patients were presenting for help with drug use, feeling more confident to approach their more familiar GU/HIV clinic, than presenting to a (possibly) frightening, or perhaps poorly informed drug support service.

Addressing needs

1. Training and techniques

Antidote's first response was to develop a training programme [5] for GU staff to instill confidence, to familiarise them with these drugs, contexts of use, associated risks and motivations for this behaviour. It included motivational interviewing techniques that could be applied to this group, to address reluctance and ambivalence about making changes to drug use, condomless sex, number of sex partners or frequency of testing. Take-home questionnaires were designed to help patients reflect on choices, risks and behaviours, again using the motivational interviewing model [6,7].

2. Improved communications

New assessments and waiting-room questionnaires were designed, using colloquial/street terms or slang familiar to the patient group, giving a range of options associated with hardcore sex practices and drug use [8]. A non-NHS website [9] featuring more explicit harm-reduction information around drug use and sex practices was developed, and a video was produced promoting the clinic [10], which was intended to go viral – all designed to reassure the patient group that they would not experience ignorance of their lifestyles at the clinic.

3. Partnership clinics

A partnership was formed with the busiest of these clinics, the Chelsea and Westminster NHS Foundation Trust's Soho-based clinic, 56 Dean Street, which saw 41,000 new patients in 2011; of whom 482 were MSM newly diagnosed with HIV. That constitutes one in every six new HIV diagnoses amongst MSM in England [11]. If all those had been monitored for sexualised drug use, the results would most certainly have informed this paper better.

This partnership started with the weekly evening clinic, 'CODE'. Targeted solely at MSM who use drugs for sex, CODE was staffed by specially skilled or trained, MSM-identifying drugs workers, peer mentors, doctors, nurses and sexual health advisors. It was marketed as a non-judgmental safe space where all things sex and drugs could be discussed. (We were fully aware that very few clinics are in fact judgmental; however, because there may have been more shame associated with this group, the non-judgmental, drug-aware message was made loud and clear in the publicity.)

A second partnership was formed with Central North West London's (CNWL) Club Drug Clinic at Chelsea and Westminster Hospital that worked exclusively with crystal meth, mephedrone and GBL (as well as some other novel psychoactive substances) – though no alcohol, marijuana, opiates or crack cocaine. Using a CNWL Innovation grant, it broke the impractical mould of borough-exclusive care and borrowed from the sexual health model of pan-London access. Despite being open to all (LGBT and non-LGBT), it was immediately at capacity, with 80% of attendees being MSM using drugs to facilitate sex [12].

Conclusion

It is arguable that the sexualised use of crystal meth, mephedrone and GHB/GBL is now the greatest threat to MSM health and wellbeing, with the consequences broadening from a small London charity to numerous statutory health services, and similar evidence appearing in larger cities around the globe. Providing holistic care for our patients has never been more relevant, with sexual behaviour and substance use being more closely connected than any time in the history of HIV. The evidence also suggests that these trends are continuing to rise rather than level out, and the projected costs to MSM wellbeing and NHS budgets could be considerable.

Workers in substance misuse and sexual health/HIV could address these behaviours and consequences with greater confidence, simply by having access to available training and improved multidisciplinary collaborative work with third-sector organisations that may be better acquainted with this patient group's needs. The language and appropriateness of assessments could be tailored to gain trust and increase disclosure from patients. The (informed) monitoring at GU/HIV clinics of patients' drug use, as well as sexual behaviour monitoring of people presenting at drug services, would enhance insight into these trends. Raising the general public's awareness of these trends will help address ignorance of these dangers both among users and within NHS services. It is also important to address loss of faith among MSM in the ability of the NHS to provide informed and tailored care around these issues.

An enormous amount of HIV prevention work is being done with this client group by Antidote workers, including ART adherence while 'high', safer online sexual behaviour, ambivalence around HIV disclosure, condom use, regular screenings and issues contributing to chaotic sexual behaviour. Although much prevention, campaign work and funding is directed at HIV-negative people, the evidence above suggests there are large numbers of HIV-positive MSM that may be in need of more focused care to address what is clearly a developing epidemic of risky, drug-fuelled sexual behaviour by some very vulnerable people.

**Antidote is an LGBT drug and alcohol support service. Data were drawn from assessments, surveys and recounted experiences, 2005 to 2013.*
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