

# ChemSex and care-planning: One year in practice

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## Introduction

Throughout the HIV/AIDS epidemic, the disinhibition and poor judgement associated with drugs and alcohol have continuously impacted our patients' abilities to practise safe sex and to keep themselves safe from infection. The GUM/HIV sector responded effectively with screening tools, busy Health Advisor teams supporting patients with risk-reduction, and robust referral pathways to drug and alcohol support services.

None the less, new HIV diagnoses have doubled in the UK since 2000, with an estimated 1-in-12 MSM in London living with HIV [1]. In the last decade, we have also witnessed the smartphone Apps and online sexual networking sites become the most commonly used means of sexual procurement by gay men, and we have seen London's gay communities adopt three new, highly dangerous drugs as sexual enablers (the practice commonly referred to as 'ChemSex') [2].

ChemSex trends have challenged the effectiveness of our existing care pathways, with traditional drug services showing limited uptake of MSM referrals [3]; the onus has fallen upon sexual health commissioners and healthcare providers within GUM/HIV services to respond to this syndemic of MSM/drug use/HIV/HCV/STIs/mental health. London's Soho-based sexual health and HIV clinic, 56 Dean Street (part of the Chelsea and Westminster NHS Foundation Trust), is the first UK model providing targeted, full time ChemSex support to London MSM in an NHS GUM setting; this article provides data from the first year of practice, and an example of care planning [4] for patients seeking behaviour-change support within a GUM/HIV setting.

## The UK ChemSex syndemic: a brief history

Though drug and alcohol use by MSM probably goes back centuries, the 1980s and 1990s were predominantly defined by the recreational use of ecstasy and cocaine. Though of concern, links to HIV/HCV/STIs as a result of this use did not compare to the more current epidemiology of crystal methamphetamine, mephedrone and/or GBL use that characterises ChemSex behaviour.

In the early to mid-1990s, London's gay scene media were reporting on the increased use of

crystal methamphetamine ('Tina', 'crystal', 'meth') and gammabutyrolactone (GBL, 'G', 'Gina'). The LGBT drug-use charity *Antidote* began seeing increasing numbers of gay men seeking support with these drugs, the majority using them in sexual contexts, defined by two- to three-day 'benders' associated with multiple partners, poor sexual health practices, poor antiretroviral adherence, rare experience of sober sex and failing mental health [5]. In 2008, mephedrone became widely available in the UK, and was widely incorporated into this trinity of ChemSex-defining drugs. (GBL and mephedrone were purchased legally and often online in 2008, before being made illegal in 2009 and 2010, respectively).

Despite the LGBT cultural dialogue occurring about ChemSex trends at this time, no research or reports were emerging from substance misuse services or GUM/HIV clinics. Two NHS services did respond to the anecdotal trends, however. In 2010, 56 Dean Street piloted a Tuesday evening clinic ('CODE' clinic) targeted at gay men using drugs for sex; and in 2011, CNWL's Club Drug Clinic at Chelsea and Westminster Hospital formed a partnership with the charity *Antidote* to address the needs of the MSM accessing its services, many of whom were presenting with ChemSex behaviours.

Reports of the growing syndemic continued to emerge in the following years from GUM services and MSM charities. In 2013, *The Lancet* published two articles on London ChemSex trends [6,7], and the journal *HIV Nursing* published a case study of data from the charity *Antidote* [5]. In 2014, Sigma Research published its ChemSex Report [8] and the Astra Study published its report on ChemSex amongst UK HIV-positive MSM [9].

In 2014, the Chelsea and Westminster Hospital NHS Foundation Trust employed a full time Substance Use Lead specifically to address the ChemSex presentations at the 56 Dean Street GUM/HIV clinic. 56 Dean Street has 11,000 individuals through its doors each month, approximately 7,000 of whom are MSM. It can be estimated, based on a survey carried out in 2013 [10] that 3,000 of these monthly presentations are MSM using recreational drugs in sexual contexts.

## One year in practice: ChemSex clinic data at 56 Dean Street

In February 2014, all staff at 56 Dean Street began targeted (and ongoing) training in ChemSex trends,

the cultural context, questions to ask patients in order to elicit honest disclosure of drug use, and how to effect a productive referral to in-clinic ChemSex support [11]. Volunteer peer-support workers were employed to staff the ChemSex walk-in clinics [12], and nursing staff/HCAs had an on-call ChemSex support worker available full time. Peer-led support groups were established to facilitate discussions on how to incorporate sober sex into a London sex life and communication skills for online sexual networking. An annual programme of community events was established (the Dean Street Wellbeing programme [13]) to stimulate dialogue and mobilise gay populations with regard to issues affecting their sexual and community wellbeing. A library of short harm-reduction videos was made available [14] to support MSM nationally, who may be reluctant or unable to physically access support.

At the end of December 2014, 874 MSM using combinations of crystal methamphetamine, mephedrone and GBL in sexual contexts had consented to a brief intervention (or multiple interventions); all data in Panel 1 were acquired at first presentation.

#### Panel 1(A)–(D):

Data collected from 874 MSM ChemSex patients at first presentation

#### Panel 1(A): Behavioural

- 70% reported no chem-free sex in previous 6 months
- 98% had never accessed statutory drug use support
- 71% were referred from within the Trust (mostly from staff at 56 Dean Street)
- 29% attended the ChemSex walk-in clinics specifically seeking ChemSex support

#### ChemSex behaviour tended to accelerate:

- Immediately after an HIV diagnosis
- Immediately following the break-up of a relationship
- Following migration to London

#### Drug using, sexually active episodes of between 12 and 48 hours were the norm

- 12% reported one partner per episode
- 32% reported two or three partners per episode
- 45% reported between four and 10 partners per episode
- 11% reported 10 or more partners per episode

#### Panel 1(B): HIV status

- 52% HIV –ve (of whom, 40 individuals were diagnosed HIV +ve at 56 Dean Street during 2014)
- 32% HIV +ve
- 16% unanswered

#### Of the HIV +ve cohort not on ARV therapy (42 individuals):

- 64% reported zero condom use for intercourse

- 10% reported using condoms for intercourse less than 50% of the time

#### Of the HIV +ve cohort on ARV therapy (238 individuals):

- 25% reported zero condom use for intercourse
- 51% reported using condoms for intercourse less than 50% of the time
- 64% reported good ARV adherence
- 30% reported poor ARV adherence (though not representing a significant danger to viral suppression)
- 8% unanswered

#### Of the HIV –ve cohort:

- 30% had accessed one course of PEP in the previous 2 years
- 25% had accessed between two and 10 courses of PEP in the previous 2 years
- 10% reported zero condom use for intercourse
- 40% reported using condoms for intercourse less than 50% of the time
- 42% expressed an interest in PrEP as an HIV prevention tool
- 33% were unfamiliar with PrEP

#### Panel 1(C): Hepatitis C status

12% of the cohort had previously tested positive for hepatitis C. Of these:

- 52% were mono-infected
- 40% were co-infected with HIV
- 68% had only been HCV infected once
- 32% had been HCV infected multiple times
- 47% had never injected illicit drugs
- 36% were injecting drug users
- 23% were HIV –ve, non-injecting drug users

#### Panel 1(D): Injecting drug use

- 29% were injecting drug users
- 34% had never injected drugs
- 37% unanswered

#### Of the injecting drug users:

- 68% reported never having shared needles
- 23% reported having shared needles
- 27% reported never having injected themselves (allowing others to inject them)
- 16% only ever injected themselves
- 30% had been injected both by themselves and others

## Developing ChemSex care plans for GUM/HIV patients

The use of online Apps and sexual networking sites allows the awareness and availability of ChemSex drugs to spread quickly beyond geographical regions, and similar reports are emerging from cities across the UK and Europe [15]. It is possible that similar harms are being experienced by patients accessing GUM/HIV services nationwide, and

perhaps being poorly identified by clinicians. In order to better identify these behaviours, and to make effective referrals to Health Advisor teams, it may be wise to incorporate some simple questions into pro formas, or into our history taking during consultations. Using culturally relevant terms can also elicit less defensive responses and more honest disclosures from our patients. Some suggestions;

- 'Do you use party drugs for sex?'
- 'What's your preferred drug?'
- 'When did you last have sober sex?'
- 'How long do you stay awake for?'
- 'Do you sometimes regret the choices you make when you're high?'
- 'Have you had any bad experiences on the second or third day awake?' (e.g. paranoia)
- 'Would you like to speak with a Health Advisor about taking a break from chems?'

When a patient does consent to a discussion about his ChemSex behaviour, a clinician can encounter defensiveness, denial, ambivalence or fear about making changes. Motivational interviewing can be the most helpful method to support these patients, though not all clinicians have the skill, experience or time to practise this kind of support. Yet something as simple as suggesting a chem-free weekend or month can be a productive intervention; and certainly more productive than suggesting stopping drug use altogether.

The downloadable Care Plan document [16], which is included in these pages, is designed to be a take-home document for our patients, or something that may be used by a clinician to guide a patient through some simple behavioural-change steps in as little as 5 minutes. Simply put, a Care Plan helps our patient through the following actions:

*Identifying a goal to achieve:* Small achievable goals are advised, such as having a chem-free weekend or month; a series of failed goals (e.g. abstinence forever) can demotivate a person, and we risk having them disengage from our services; a successfully achieved goal, however small, gives a person a sense of accomplishment and motivates them to pursue greater goals.

*Identifying circumstances/situations likely to cause a craving or lapse in behaviour:* These can include compulsive use of sexual networking Apps/sites, being bored/unoccupied, invitations from sex-buddies, attempts to have sober sex, drinking alcohol, clubbing, certain times of the day/week.

*Tips for managing triggers and cravings:* Not making impulsive decisions; changing one's emotional state by getting out of the house or calling a supportive friend; distracting oneself from the craving by other means/hobbies; having a full diary of things to do, preferably with friends; other tips available online [14].

*An invitation to return to follow up the care plan.*

## Case study

RJ is a 26-year-old HIV-positive patient (of 5 months), not yet on ARV treatment as he feels he is not emotionally ready for the commitment, with which his doctor concurs. RJ's drug use accelerated somewhat following his diagnosis, something he feels ashamed of and has not confided in his healthcare team for fear of judgement, or of being referred to an abstinence-based programme in a drug unit.

RJ's drug use involves going out clubbing each week, snorting some mephedrone, and going to post-club chill-out parties where he has sex with (usually) one partner, before leaving and seeking other partners via the use of geo-location sexual networking Apps. He avoids the discussion of HIV status, and finds the ChemSex scene preferable, as HIV is rarely discussed in these environments. Many of his partners do not suggest using condoms, and he assumes this means they are HIV-positive too, so does not feel the pressure to use condoms during these encounters.

He had been asked, when diagnosed, if he was an injecting drug user, or if he had had sex with an injecting drug user, to which he replied (honestly, and to the best of his knowledge) not. He had assumed this meant he was not at great risk of hepatitis C, but having read a ChemSex/hepatitis leaflet [17] in the clinic waiting room, he asked a nurse on his next visit for a GU screen, to test him for HCV.

The nurse on duty that day was well informed about ChemSex behaviours, and during a friendly discussion about how he had spent the weekend, asked RJ what his favourite drug for clubbing was. RJ, somewhat surprised at the lack of judgement, responded that all the guys were doing 'meph', and that he had tried it. A friendly discussion followed, during which RJ disclosed his own use of mephedrone (and GBL) for sex and clubbing.

Other questions which came up during the consultation were; 'Have you met anyone special while out on your weekends?' (which made RJ reflect somewhat on the quality of the sexual experiences he had been having), 'When did you last have sober sex?' and 'When was the last time you spent the weekend with a good friend doing fun stuff?'

RJ was then asked if he wanted to try a chem-free weekend, or maybe two. He was reassured that a Health Advisor in clinic could support him with this if he wished, and though he was not ready to make that appointment, he did take home the copy of the ChemSex Care Plan which the nurse had helped him to complete.

Three weeks later, RJ had lost/forgotten about the

*continued over*



# Care Plan, ChemSex



**Part 1: What is your goal?**    Abstinence?     Reduced use?     Controlled use?     Safer use?

To keep your goals small, realistic and achievable, and to gain a feeling of accomplishment...

Try committing to a period of abstinence (with our support for); 1 month     2 months     3 months     4 months

How confident are you to achieve this goal?

Not confident    1    2    3    4    5    6    7    8    9    10    Confident

Is your confidence score is less than 7? Re-adjust your goal to improve your confidence

Abstinence goal;    1 week     2 weeks     3 weeks     1 month

Now rate your confidence level again (and keep adjusting until your confidence level is 8 or higher)

Not confident    1    2    3    4    5    6    7    8    9    10    Confident

## Part 2: Managing triggers

(These can be boredom, loneliness, feeling horny, playing on Apps/hooks-up sites, times of day, journeys home from work, etc)

When are your cravings/triggers likely to happen?

Home alone     weekends     Friday/Sat nights     When playing online     When drinking

Name others: \_\_\_\_\_

What can you do differently next time you feel a craving/trigger?

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What supportive person can you call if you feel a craving/trigger?

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What enjoyable/productive things can you plan into your upcoming free time, to keep yourself occupied?

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It might be wise to abstain from sex, as well as sex apps, during this vulnerable time, as it might trigger you further. If this is unlikely, or unattractive to you, what might you have to do differently to enjoy sober sex?

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## Part 3: Follow-up support? When can you return to follow-up your Care Plan?

continued

Care Plan, but each ChemSex experience he had had since had felt different; somehow he could sense an emptiness and silliness about the experiences, and was more aware of a self-harming element to his weekends. He returned a month later and booked an appointment to see the Health Advisor, who supported him through a month of chem-free weekends. The Health Advisor was also able to explore with RJ his concerns around ARV treatment, and the advantages (to RJ, his sex-partners and his broader gay community) of having an undetectable viral load. This had been explained to him on the day of his diagnosis and during a follow-up appointment, but he hadn't taken it in fully.

Six months later, RJ was not entirely drug-free, nor was he very confident about sober sex, or disclosing his HIV status when on dates; but he was on ARV treatment with an undetectable viral load, and engaged happily with his local GUM clinic, which he felt confident to access during his ongoing, fluid relationship with his own sexual wellbeing and continuing flirtations with ChemSex.

## Summary

Nurses and clinicians working in HIV have a long, proud tradition of working creatively with a challenging and constantly changing epidemic. In the late 1970s, nurses were as much activists as they were healthcare providers, providing care for a panicked and stigmatised population of terminally ill patients, and it is with this pedigree that we now support a new population with (again) a challenging, stigmatised and poorly understood pattern of behaviours. Additionally, and as a direct result of the HIV/AIDS epidemic, gay men have formed uniquely fond relationships with GUM clinics, many of them able to name a preferred clinic and even a favoured worker within a clinic. Gay men struggling with ChemSex (consciously or otherwise) have demonstrated a preference to discuss their complex sex lives with us, the GUM/HIV sector, over a heroin-entrenched substance misuse sector. It is a joy and privilege to have this population's trust, and I've no doubt we're up to the job of guiding our patients through this challenging syndemic toward healthier and happier sexual wellbeing.

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