Resourcing peer support volunteers in HIV prevention and sexual wellbeing: NHS settings

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Introduction

Nursing staff in sexual health and HIV settings may find themselves busier than ever before, as HIV diagnoses amongst gay, bisexual and other men who have sex with men (MSM) continue to rise [1], and as MSM face newer challenges around their sexual wellbeing and behaviour. HIV stigma, community PrEP debates, the increasing use of geo-sexual networking Apps, and ChemSex trends [2] are bringing more MSM into our services and, in some cases, challenging the amount of time or care we are able to devote to them in our consultations. And in a climate of cuts and austerity, this is a concern [3].

It has always been a comfort that there is a resource of gay men's support services and charities, staffed in many cases by passionate volunteers and peer support workers, to which to refer our patients [4], so we know that the underlying complexities that bring our patients into clinic may be addressed.

That said, how practical is it for NHS services to resource volunteers or peer support workers to lighten the loads and improve holistic care in our own clinics? When 56 Dean Street first considered opening targeted ChemSex support clinics in 2010, data that connected sexually transmitted infections (STIs) or HIV to ChemSex behaviours were very much lacking. It was difficult to justify a single paid role devoted to drug use support in this setting, let alone to staff a ChemSex clinic with drug support workers. There was no precedent for this, and no tariff allocated for it. Drug users were referred away in most cases, to substance misuse services – services that may not always be the most skilled or conducive to the needs of gay men engaging in ChemSex [5]. Yet the need to address ChemSex behaviours on site was evident [6], and (if only anecdotally at the time), quite urgent.

Complicated sex lives

Of course, the needs of our patients engaging in ChemSex can go well beyond the remit of GUM/HIV nurses and staff in substance misuse services. The sheer volume of safer-use information required to avoid harm [9] can be overwhelming for a recreational user who discovers these drugs (or 'chems') online. How to dose more safely, given the potential for toxicity or overdose when using GBL (gammabutyrolactone – one of the recreational drugs associated with ChemSex), is a skill that, more often than not, is only learned through trial and error [10]. The 'error' being defined as a trip to Accident and Emergency, a sexual assault or (too commonly) a fatality. Skills such as how to inject mephedrone more safely, which drugs ought not to be mixed with alcohol or other drugs, or which drugs might interact badly with antiretrovirals [11] are vital. Very complicated information is required to use these drugs safely, yet these drugs are very commonly used by

Why not simply refer ChemSex patients to a substance misuse service?

Imagine for a moment, two men sitting in the waiting room of a substance misuse service.

The first is a heterosexual male: street homeless; hepatitis C (HCV) positive; injecting heroin daily; and occasionally sharing needles. Clearly flagged within this setting as high risk: dangerous withdrawal symptoms; HCV transmission risks; and, with regard to poverty/homelessness and possible crime reduction initiatives, a public health 'burden' that may equate to thousands of pounds per year.

The second is a gay male: HIV negative; HCV negative; and using recreational drugs only twice a month, having never injected. He is employed, owns his own home and enjoys robust support networks. There is very little here to flag as high risk in a substance misuse setting. However, if he was sitting in the waiting room of a sexual health clinic, having a sexual history taken, it may be identified that he is having between 5 and 10 sexual partners per drug-using episode. It may be identified that he rarely uses condoms when having sex under the influence of these recreational drugs. According to algorithms used at 56 Dean Street [7], and to any well-trained GUM/HIV nurse, this patient is highly likely to become infected with HIV within the next 3 to 6 months; and before we can get him tested and on treatment (as prevention), he is likely to infect between possibly 10 and 30 other gay men within the next 6 months to a year.

Very clearly, the second man is a high risk in a GUM/HIV setting. And in regard to public health, he could represent a cost that could amount to (considering onward transmissions), millions of pounds per year [8].

Addressing ChemSex in GUM/HIV settings provides these patients with the correctly trained staff to address the most acute concerns associated with ChemSex, perform the most appropriate risk assessments, with knowledge and skills around sexual behaviours, HIV prevalence, ARV adherence, drug–drug interactions (DDIs), and experience with MSM cohorts that includes an ease in discussing gay sex.

our MSM patients, often with a very poor harm-reduction skill set [12].

Beyond this essential drug-use information, many of the sexual needs of our patients are related to HIV stigma, cultural concepts of sexual identity, sexual liberation, and awareness of their own sexual/emotional needs and desires. Navigating the easy availability of recreational drugs on geo-sexual networking Apps is certainly a challenge for gay men in big cities in 2016 [13]. Possessing the boundaries and communication skills to seek sex and romance via the use of new technologies can also be difficult, and the lack of these skills is often translating to less satisfying or riskier sexual experiences [14]. 'Slut shaming' and online rejections based upon race, effeminate qualities or attractiveness are common experiences for many of our patients, further complicating their search for sex and relationships. It takes a well-educated and confident person to discuss/disclose safer sexual preferences while using online platforms, not to mention to be able to negotiate these amid a climate of undetectable viral load disclosures, sero-sorting and PrEP sourcing [15].

If we are to support our patients holistically, the ideal multidisciplinary team in clinic would involve peer support workers from gay communities, who have robust cultural awareness of these issues, some lived experience of these everyday challenges, and some skills in negotiating their own sex and romantic lives through these very complicated psychosocial environments.

The role of the volunteer

In 2014, 56 Dean Street launched its Sexual Wellbeing programme [18], a series of community-engagement events involving photography exhibitions, theatre performances, film screenings, open-mic nights and panel discussions. This initiative strove to improve upon the focus group format, supporting clinicians, management and commissioners in better understanding the complex lifestyle needs and challenges of our local populations, challenges that can lead to poor sexual health and wellbeing.

An early lesson from the Sexual Wellbeing programme was that MSM seeking support with ChemSex behaviours preferred workers with cultural awareness of the lifestyle challenges they experienced, particularly around the pursuit of relationships, sex and the technologies they employed in pursuing these. This seemed particularly important when it came to the psychosocial 'interventions', or the behaviour change support that the frontline clinical staff might be referring them to [18]. And so, as a complement to the health advisor teams that were already doing extraordinary work with this cohort, 56 Dean Street's ChemSex support services recruited for a team of peer support workers, volunteers from the local gay communities, to be trained in providing brief interventions for patients accessing the service. Though these volunteers may lack the medical or therapeutic training that nurses, doctors or health advisers possess, they could be recruited on an assessment basis of cultural competency: an experience of online 'hooking up' challenges; an awareness of living with HIV stigma (regardless of status); a cultural awareness of the bar, club and sauna scenes; an inherent understanding

Typical scenario: a nurse in the busy Dean Street Express Testing Centre

Dean Street Express is 56 Dean Street's second building, designed to be a fast-track, low-threshold sexual health screening centre for asymptomatic patients only. It has approximately 500 people through its doors each day, with patients queuing before opening time on certain days of the week [16].

On any given day, a nurse in this clinic might see between 20 and 40 patients over the course of a shift [17].

Patient 1: 22-year-old MSM presenting for a GU screen, having spent the weekend in a sauna with multiple partners, using chems. Unable to give a detailed history of the weekend due to intoxication, he reports having possibly passed out for a 3-hour period; he is convinced sexual activity may have occurred during this lost, intoxicated time. Despite the nurse's enquiries and offer of referrals/support, the patient claims that it was not an assault, that it was his own fault for taking too many drugs, and that this was a common, even normal experience that happens to him and his friends in saunas. Suggests that the nurse is making a 'drama out of nothing'.

Patient 2: 30-year-old MSM presenting for a PEP assessment after a possible chem-related HIV exposure. When asked by the nurse the status or viral load of the sexual partner involved, and further details of the incident, or whether the person involved might be in the waiting room or contactable to help inform the PEP assessment, the patient giggles and claims it could be any one of eight men he had sex with over the weekend, and that he doesn't know any of them. Recognising that this is the patient's fourth PEP presentation in the last 12 months, the nurse suggests a chat with a health advisor, to support the patient to negotiate risks more effectively. The patient declines, stating casual sex is his right, not displeasurable at all, that condom mishaps are normal for everyone, and that he is well-informed to access PEP when risks occur.

Patients 3 to 20 (or so) throughout the day: all similar in presentation and risk, and all similar in how the patients perceive these risks to be normal, acceptable parts of their sex lives. GBL overdoses, issues around consent while intoxicated, life-changing HIV infections from nameless, forgettable partners… These ought not to be everyday, acceptable parts of anyone's sex life.

This is a great deal of emotional weight for a nurse to take home at the end of a busy work day. There is, of course, plenty of support from colleagues, management and supervision groups. And though it would appear that many of our patients have normalised these risks, it is important that busy GUM/HIV nurses do not become complicit in this normalisation. That we remember that all our patients deserve enjoyable, satisfying sex and romantic lives, with less risk or trauma, even if they have poor awareness of their deservedness.

The ChemSex clinic peer support worker's journey

All requests received to volunteer for the 56 Dean Street ChemSex support clinics are considered, and applicants are invited to submit a CV and covering letter. Experience we would be looking for might include previous volunteering experience, having worked with vulnerable people, or some training in medicine, counselling or social work. We would be looking for qualities or experience that suggest an understanding of boundaries and confidentiality, some compassion, and/or a robustness to cope with behaviours that might challenge one's own ethics, morals or emotional strength.

Interviews are conducted with a multidisciplinary panel, making use of scenarios that explore how volunteers might deal with crisis presentations, confidentiality or working within a team. Given that gay communities can consist of small, familial networks, issues are explored about how applicants might model good behaviour when in public or communicating online.

Successful applicants are provided with honorary contracts, and then undergo three months of training before they begin any one-to-one work with patients. Training involves motivational interviewing, sexual health, risk assessments, harm reduction and relapse prevention work, care planning, and the shadowing of ChemSex support interventions, as well as other skills relevant to the role.

Volunteers are supported with individual and group supervision, and ongoing training. Depending on individual interests and skill, other opportunities exist to contribute at conferences, social events, developing health promotion campaigns or co-authoring journal papers.

One might summarise the volunteer's role as supporting patients to identify goals for behaviour change, be that reducing the risks/harms associated with drug use (sexual risks or otherwise), helping patients to gain more control over their drug use, or to stop altogether, depending on the patient's goals. The most successful outcomes result from casual discussions about gay sex: exploring what patients want from their sex/romantic lives; how to pursue this; how to use sex Apps more productively, and how to enjoy satisfying social lives amongst their friends, family and communities.

of the drugs that are available and how one might be introduced to them, or tempted by them. And the many other idiosyncrasies associated with modern gay lifestyles.

Gay communities have a proud history of community support. Throughout the early years of the AIDS epidemic, gay men were amongst the many who provided volunteer support to wellbeing services and community groups responding to the crisis [19]. And though HIV care is certainly less urgent in the UK in 2016, the tradition continues. Terrence Higgins Trust [20], London Friend [9], Positively UK [21], Positive East [22], Metro [23] and many, many other support services are staffed, almost entirely in some cases, by volunteers and peer support workers (however 'peer' may be defined). At this time of particularly unique challenges for gay men, it would seem unwise not to resource this wealth of community concern and cultural competency.

Conclusion

It is important to note that the peer support worker's role does not undermine, or mean to replace, that of nursing staff, therapists or health advisors in sexual health settings, but to complement it. The role might be defined as lifestyle mentoring for a population of gay men who are struggling to adapt to some unique difficulties associated with sexual behaviour and identity. The role supports community engagement, helps us to learn more about our patients' needs and concerns, and reassures our MSM patients that there is great resilience and cohesion within small communities, even when they appear to be struggling. Hopefully too, it bridges any perceived gulf that might exist between marginalised groups and NHS care.

Busy nursing staff, in busy sexual health settings, can sometimes feel that they don't have enough time, or follow-through with their patients. And they are often taking home a huge weight of unresolved concern for these very vulnerable people. Particularly when working on the front line of gay men's sexual health, where there is so much normalised risk taken for granted. Hopefully, the additional support offered by peer support workers and volunteers from gay communities can offer some comfort and reassurance that their extraordinary work is valued and complemented by these teams.

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