Commentary

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> **Chemsex** How physicians should approach the sexual health syndemic

> **Going to the dogs?** The use of canine and electronic noses in identifying disease

> **Health and the homeless** The results from the RCP's survey of members and fellows

Dementia and care

The person-centred approach to hospital patients with dementia

Royal College of Physicians

What you need to know about chemsex

When health issues are discussed in the media, misinformation and hyperbole often follow, and the topic of chemsex has been no different. However, the hype has raised awareness in a way that had not previously happened, focusing a spotlight onto a burgeoning epidemic that for too long has kept to the shadows. **Odhran O'Donoghue** separates the facts from the fiction.

In November of 2015, a piece in the *BMJ* provoked a minor frenzy in the mainstream press, generating a flurry of articles which ranged from the informative to the pearl-clutching. In many ways, the furore was unsurprising, because the topic was chemsex, and chemsex is ideal fodder for media sensationalism – a perfect storm of drug use and sex in a marginalised community that makes for salacious headlines. Furthermore, the timing was right, with a documentary, *Chemsex*, released weeks later.

What is chemsex?

Chemsex is a term used mostly in relation to men who have sex with men (MSM), to describe the use of drugs during sexual activity, which is increasingly associated with unsafe sexual practices and sexually transmitted infections. Sexual liberation and recreational drug use have a long history in the gay community, but 'it's important to understand that it's not just self-indulgent, promiscuous, drug-taking gay men, but actually vulnerable people going through a huge cultural change,' says Mr David Stuart, the substance use lead at the 56 Dean Street sexual health clinic in London.

In the past 10–15 years, the landscape of gay sex has transformed, producing this new and unique syndemic. First, approaches to HIV treatment and prevention have changed substantially: 'PEP [post-exposure prophylaxis] and undetectable viral loads became more a part of the cultural dialogue, and now there's PrEP [pre-exposure prophylaxis] – HIV prevention now is very complicated. It's a lot to take to the bedroom,' says Stuart. 'Second: three new drugs landed in a population that had already adopted and normalised recreational use of low-harm drugs.'

The three drugs are methamphetamine, mephedrone and gamma hydroxybutyrate (GHB), which are anything but low harm. They cause sexual disinhibition, and are associated with poor condom use, despite good community awareness of their importance, more sexual partners and high-risk sexual practices, such as fisting.

According to Prof Jane Anderson, a consultant HIV physician at Homerton Hospital in Hackney, 'these substances are associated with unsafe sex. Even the best-prepared people will find it difficult to implement their knowledge if they're not able to focus and concentrate.' More and more people are injecting these drugs too – known as slamming – which introduces a host of additional risks.

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The third major change was the advent of sexual networking apps, such as Grindr, which have changed how gay men find sexual partners, by removing the need for socialising and allowing easy access to drugs. The combination of these factors has led to devastating consequences, particularly in cities with large gay populations.

The facts

Rumours about sexualised use of a new wave of drugs spread as far back as 15 years ago in the gay clubbing community, but wider awareness and action were slow to emerge. Part of the problem was that the people engaging in these practices got lost at the intersection between the substance misuse and sexual health sectors. 'The ball was thrown back and forth for 10 years and nothing was done,' says Stuart.

Even within the gay community, chemsex was often written off as the debauched activities of a minority, and the mainstream gay press were silent on the issue. 'Then there were the MSM drug users themselves, who had adopted these behaviours as the normalised way they socialised and had sex. And they didn't want to talk about it either, because they don't consider themselves to be abusing drugs,' says Stuart.

As late as 2010, there was no connection between the rumours and adverse health outcomes, and the problem wasn't measurable. Although things are improving, the dearth of data remains a big challenge. 'We're working in a cloudy area of anecdotal reports and known associations,' says Stuart. 'It's really challenging for a medical profession trying to say that it's a problem.'

Much of the initial evidence came from qualitative studies, although some quantitative data have begun to emerge. In a 2014 study of sexual behaviour in people living with HIV, more than half the 2,248 MSM included had used drugs in the past 3 months, and almost 25% had used more than three drugs. But Stuart warns that this might not be representative: 'It's too easy. HIV-positive men access treatment. The risks are in people who don't access clinics very well.' 56 Dean Street has some data of its own. A 2013 survey showed that around 3,000 of the 7,000 MSM who attended the clinic every month were using chemsex drugs. Last year, they published findings from a survey of 874 men involved in chemsex. Sexual episodes of 12–48 hours were found to be the norm, with 45% reporting 4–10 partners per episode. 32% of the cohort was living with HIV, and 12% had previously had hepatitis C (4% had been infected more than once). 29% were injecting drug users (a further 37% did not answer that question), and 70% had not had sober sex in the previous 6 months.

'We know what's happening at Dean Street – the rest is anecdotal,' says Stuart. 'But we know it's happening, and that it's getting bigger.'

Prof Anderson is currently seconded to Public Health England, who are working on updating surveillance methodologies to allow data related to sexualised drug use to be captured more easily. Even though it's difficult to pin these health consequences specifically on chemsex, experts in the field are in no doubt about the harms that the behaviour causing. 'We are certainly seeing people whose lives are being very badly damaged or even lost to chemsex. It is causing ill health, and people who deal with ill health need to know what's happening,' explains Prof Anderson.

'We have epidemics of HIV, hepatitis C, gonorrhoea and syphilis,' she continues. 'There's unsafe injecting practices, which allows transmission of bloodborne viruses.' This, coupled with inconsistent condom use, allows infections to spread rapidly. 'It's possible that at just one party, there are between three and six new HIV infections,' says Stuart, who attributes the surge in HIV and hepatitis C infections in London and possibly other UK cities to chemsex. These newly infected people could then attend another chemsex party the following week, unknowingly exposing the other attendees to HIV. Thus, increased awareness of seroconversion symptoms is extremely important.

But the risks extend beyond just STIs. 'We are very clear that there are issues surrounding mental health and mental wellbeing: MSM have higher levels of poor mental health than the general population,' says Prof Anderson, and GHB, mephedrone and methamphetamine can all significantly affect mental health. Drug overdoses are becoming more common, and GHB has been linked to several deaths. For patients on antiretroviral therapy, there's also a potential risk of drug interactions.

Taking action: the bigger picture

'People in this situation are increasingly likely to come to the attention of health services,' says Prof Anderson. Although not all health professionals will have an in-depth level of expertise, it's really important that you know who to call and where to signpost to.' However, to address problematic behaviour you first need to be able to identify it.

'Clinicians need to ask the right questions in a way that will gain trust, which is something that all physicians should be trained to do,' she says. People living with HIV still experience stigma in healthcare situations, 'and if that's the case for people with HIV, it can be even more difficult to raise the issues of sexualised drug use.'

To promote honest disclosure, Stuart emphasises the importance of cultural awareness – understanding the mindsets of the patients. Cultural awareness means knowing to ask patients about party drugs rather than injection drugs (which many patients presume means heroin). It means knowing not to use the word 'addiction' ('most of the guys coming to our clinic aren't identifying a drug problem, they're identifying a sex problem'). Cultural awareness even extends to prevention and treatment – such as knowing that patients might need dozens of clean needles for a chemsex party ('people will inject many times, and there might be four to seven other people – four needles is not going to do the job') or that an antiretroviral regimen that is more forgiving to missing occasional doses might be more appropriate.

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However, cautions Stuart, this is just damage control and 'unless we refer to effective, culturally appropriate behavioural change support, we're dangerously letting down our populations and they'll become reinfected again and again.' At 56 Dean Street, he runs a Chemsex Support Service staffed by volunteers trained in motivational interviewing, which is accessed by around 100 new patients each month. 'We support patients to have healthy, robust, emotionally aware satisfying sex and romantic lives, which will by default translate into fewer infections,' he says. 'Advisers help them to reflect on what they want and to identify goals and gently support achievement of these goals.'

Wellbeing, and particularly sexual wellbeing, is at the heart of everything, and could be central to tackling the upstream causes. 'Chemsex is a symptom of something bigger: there is a need to look much more broadly at why people engage in sexual activity that has these dangers attached to it,' says Prof Anderson. 'There is a sense that people are looking not only for a good time, but also for intimacy,' she continues.

Stuart believes that because many gay men grow up feeling isolated and unable to express their true selves, they do not learn intimacy, a problem which has been exacerbated by the lack of explicit LGBT sexual relationship education in schools. This leads to young men trying to negotiate adult relationships with no real frame of reference, and 'for people feeling unconfident or anxious or who are finding intimate relationships difficult, anything that reduces inhibitions is attractive,' says Prof Anderson.

To tackle the harms of chemsex more broadly, specialised services like those at 56 Dean Street are needed. Public Health England have published a briefing for commissioners and providers about chemsex, and with responsibility for sexual health, HIV prevention and substance misuse services now lying with local government, there is a prime opportunity for tailored, joined-up commissioning of culturally appropriate services that could reduce the delays seen when referring patients to drug services ('in that time, the potential for HIV and other STIs to be spread by sexualised drug use is phenomenal').

Stuart is calling for national guidelines for how to screen, refer and prescribe for chemsex patients, and overall is confident that the issue can be managed: 'Let's endeavour as professionals to see this as no more than a health syndemic. Let's work hard to address this vulnerable population with improved surveillance and support.' But he doesn't want to wait around.

He believes that the model that he has pioneered at 56 Dean Street could be easily applied in other sexual health clinics: 'With just a little reading and training, existing staff can very easily support changes to patients' sexual behaviour, including drug use. Have someone from the drug service who can give out needles, and sexual health staff who know what antiretrovirals patients should be on and can help with adherence.

'As for the referral pathway, we've got the health advisers already, who support patients with their sexual behaviour, help them to identify risks, set boundaries and reflect on what they want: that is chemsex intervention. You've got a robust clinic: a small, targeted service that costs no money, and you can do that tomorrow.' ■