Chemsex behavioural support

Making changes, creating a Care Plan

David Stuart

Abstract. Chemsex creates a challenging syndemic of differing factors, including (but not necessarily defined by) recreational drug use. The public health consequences are seen in sexual health clinics in greater volume than in substance misuse services, placing a significant responsibility on clinicians and staff in sexual health settings to develop effective responses to these behaviours.

This article seeks to support healthcare providers in sexual health settings to elicit honest disclosures from patients during sexual history-taking, to competently assess risks, and to effect successful referrals to appropriate support. For healthcare providers or lay people unable to access appropriate support, this article aims to provide a step by step guide to help patients using a series of behaviour-change prompts, while empowering them to make objective, informed choices and reduce harm.

Introduction

Chemsex or 'party 'n play' refers to the use by men who have sex with men (MSM), of any combination of, most commonly, the following psychoactive drugs or "chems" - crystal methamphetamine, gamma hydroxybutyrate/butyrolactone (GHB/GBL), mephedrone – to facilitate or enhance sexual activity usually accessed via "hook-up" apps such as Grindr.

Although chemsex may be associated with varying degrees of harm, for most individuals it is a recreational activity and the majority of gay men engaging in chemsex do not feel the need to access structured drug use support[1]. Mental health problems resulting from recreational drug use, such as such as depression, anxiety and loneliness, might be ignored or tolerated by affected individuals for a period of time before seeking professional help, however, symptomatic sexually transmitted infections (STIs) or a frightening sexual health risk will, in most cases, necessitate engagement with professional services. The sexual health consequences of chemsex represent the most urgent public health concern[2], and provide the health sector with the greatest opportunity to engage with this vulnerable cohort. As we seek to understand, and respond to the challenges of chemsex, we cannot ignore this opportunity to engage with this group and offer support for individuals engaging in a behaviour that has serious consequences for patients and with potentially significant impacts on work, family and life in general and which contributes to significant sexual ill-health.

Drug use is often associated with ambivalence or reluctance to make changes and denial of the consequences[3]. A person using drugs can come to rely on the drug quite emotionally, and fear of functioning without the drug can make a person blind to consequences that might appear obvious to others. Motivational interviewing[4] is a style of communication designed specifically to help a person acknowledge that very fear, reluctance and ambivalence associated with a particular behaviour, and nurture them safely to a less fearful, more conscious and objective awareness of their behaviour and choices, so they are better positioned to make any changes they deem appropriate.

"Interventions" are sometimes applied in circumstances where they are not welcomed. In this regard, one could argue that this is an inappropriate word for drug use support, where it is crucial that any input be welcomed lest it be met with defensiveness and rendered ineffective. Despite this, motivational interviewing forms the basis of behavioural and psychosocial interventions used by drugs workers, health advisors, adherence nurses and social workers internationally.[5] This article will describe a method of psychosocial/behavioural support tailored specifically for gay men engaged in chemsex,[6] and for the healthcare providers and others who support them.

Identifying chem use, risk assessments and referrals.

Many sexual health proformas do include questions about drug use, but do not always allow for the defensiveness, denial, or reluctance of patients to answer them. In most cases, the reason for the presentation will not be the drug use, and patients might fear they will be judged, criminalised or possibly worse, referred to an addiction service for disclosing their drug use. Tailoring these questions to the cultural and often colloquial idiosyncrasies of this population can elicit more honest responses to drug use questions. (**See Box 1**).

Box 1 Questions to elicit honest responses from chemsex patients

Less effective questions might include;	**More effective questions might include;**
"Are you an illicit drug user?"	"Do you use party drugs for sex?"
"Do you use illegal drugs?"	"Do you use recreational drugs for sex?"
Are you an intravenous drug user?"	"Do you use chems for sex"
"Any substance abuse issues?"	"What's your preferred drug for sex, if any?"
"Any problems with addiction?"	"Is there anything about your drug use that you want to discuss, no obligation to make any changes?"

If the response to any of the above is affirmative, clinicians should gather further information to specifically target the needs of the individual, such as:[7]

- Number of sexual partners per chemsex episode
- Frequency of chemsex episodes
- Long gaps between sexual health/HIV screens/poor engagement with sexual health/HIV/hepatitis C (HCV) clinic appointments
- Consistently poor condom use when using chems
- Frequency of STIs in previous 6 months/multiple reinfections of HCV
- High frequency of post-exposure prophylaxis (PEP) presentations
- Seroconversion symptoms that might be disguised as a drug ‘high’ or a drug ‘comedown’
- HIV positive but not on treatment
- Consistently poor antiretroviral adherence if HIV+ve (enough to jeopardise viral suppression/increase infectiousness)
- Drug-drug interactions[8]
- Poor adherence/dosing if using pre-exposure prophylaxis (PrEP)
- Symptoms of drug-induced psychosis that might warrant a risk assessment.[9]
- Dependent gamma hydroxybutyrate/butyrolactone (GHB/GBL) use (daily for more than 7 consecutive days) which can be associated with potentially fatal withdrawal symptoms if discontinued suddenly.

Following on from this, clinicians should make an assessment of the patient’s readiness to make changes, and consider a referral to behaviour-change support (Box 2)

Final questions that often trigger reflection or action in a patient include:

“Are you happy with your level of chem use?”, “When did you last have sober sex?” and “Do you feel your chem use is negatively impacting your sex life or general wellbeing?”[7]

Box 2 Making a referral to behaviour-change support	
If a referral seems welcome: "I understand that this is more of a gay sex issue than it is an addiction issue for some; I'd like to find the right support for you (This might be support around sexual behaviour and choices, helping at a local charity, or addiction services, or counseling). If you have 15 minutes, we can do this online support tool[6] together to help you choose a goal to work towards in the coming weeks. This can help us both to determine the type of support you need, and you will be able to learn some self-care skills along the way."	**If a referral seems unwelcome:** "I'm pleased you're not experiencing any problems. If anything changes, if you find you're unhappy with the frequency of your partying, or nervous to try sober sex, if you start missing days at work, or just want to take a break for a while, do come back to us. I understand that you don't feel that an addiction service isn't appropriate at the moment and that this is more about gay sex and hooking-up issues than it is about addiction, so we'll find the right way to help you make the changes you want."

Behaviour change support: identifying a goal.

The first step in chemsex behaviour change would be supporting a patient to choose a goal to work towards. Although healthcare professionals may have their own opinions and preferences for the changes they think are best for patients with regard to chem use, an "intervention" is only likely to be effective if it concentrates on the patient's goals, and not those of the healthcare professional, though it is acknowledged that these may coincide. Ensuring patients know that the healthcare professional cares about them is important, but without the patient's own desire to change, success is unlikely.

Goal 1: Harm reduction.[10] A great many patients engaging in chemsex will not be desirous of behaviour change support; this may be the case even when they have presented with the consequences of drug use. If drug use is likely to continue, the duty of the healthcare provider is to give patients the information and tools to reduce the amount of risk that might accompany chemsex. This may consist of routine safer sex information, including HCV transmission risks in a chemsex environment[11], apart from STI risks[12], noting that these may occur as a result of not only injecting drug use or fisting but also as a result of the mucosal trauma that is often associated with the extended sex sessions that occur in a chemsex environment.[11]

Needle and syringe provision within the sexual health setting is crucial as patients are often reluctant to visit an addiction service for safer injecting equipment. It is important that patients are given sufficient supplies of these to take into account the fact that injecting may be done multiple times over several days, often in very social settings. A shortage of needles may result in sharing of needles and infection risks. Chems-specific safer injecting information is available online.[13]

Chem-specific harm reduction information would include advice about safer ingestion of chems and information about crystal methamphetamine, mephedrone and GHB/GBL (the three drugs most commonly associated with the greatest chemsex risk), plus links to others. It would also include information about safer behaviour in a chemsex environment, safer use of “hook-up” Apps[14] such as Grindr, and what to do in the cases of an emergency. The most common emergencies in regard to chemsex are drug-induced psychosis, GHB/GBL overdose, sexual assault and HIV infection risk necessitating post-exposure prophylaxis.

It is important to note that a great wealth of safer-use information is shared amongst the chem-using community itself; trial and error has skilled a great many chem-users in harm-reduction techniques. However, there are also a lot of myths that exist in communities about safer chem-use, so it is wise to have some online or hard copy harm

reduction resources[15, 16, 17] for patients who communicate a desire or likelihood to continue using chems.

Goal 2: Abstinence.[18] This is a commitment to a significant life-change, one that can require huge courage and determination, radical changes to friendship networks, to how social time is spent, and robust communication skills and boundary negotiation. It can be especially difficult for a person whose sex life and social life are co-dependently linked to chem availability and the cultural normalisation of chem use. A patient seeking abstinence as a goal needs to be very determined, very well-supported or both. They will need to be skilled at relapse prevention techniques, at identifying the triggers that can bring on a craving, and at managing the cravings that will inevitably occur (see below). Abstinence is sometimes chosen as a goal out of desperation, following a traumatic chemsex episode, or in the throes of a drug "comedown". If a person is emotionally committed to abstinence, the Twelve Step addiction programmes in groups such as Narcotics Anonymous, Crystal Meth Anonymous (and Sex Addicts Anonymous which can be helpful for the psychosexual components of chemsex) can provide daily support in most big cities that host gay communities; many of them have LGBT specific groups. It's important to remember that these Twelve Step groups are peer groups and not governed by or facilitated by qualified healthcare professionals. Although there are safeguarding guidelines written into the literature, they are not overseen by a governing body.

Addiction services and therapists can also be helpful given the significant commitment that abstinence requires. For the purposes of the sexual health setting in which the presentation occurred, it can be advisable to suggest the patient break down this large goal into smaller, manageable chunks[19]; see Goal 4.

Goal 3: Addressing ambivalence.[20] Quite often, when presented with options about chem-related behaviour change, patients can struggle to decide what to do. They may

be fearful of the work required, fearful of having sober sex, fearful of disengaging from a network they enjoy, or simply fearful because they have never before reflected on the consequences of their chem use. They may never have thought about the kind of sex life that they want, or that they may not possess the tools to achieve the sex and romantic lives they prefer. Weighing up the pros and cons, as well as responding to some open, unbiased questions might help them to consider these issues and the role that sex and chems play in their lives. (Box 3.[21]) Patients will be better aware of their support needs after completing this questionnaire.

Box 3: Some examples of questions that might trigger reflective thought

What's the best sex I've ever had?

What's the worst sex I've ever had?

What percentage of my sex life involves chems?

What percentage of my sex life is sober?

(What would I prefer that percentage to be?)

Do I feel more confident and sexy with a stranger?

Do I feel more confident and sexy with someone I've formed a bond with?

Do I feel confident and sexy when sober?

Am I prioritizing chemsex over other (non-sexual) social activities (family, friends, hobbies)?

What do I like most about chemsex?

What do I dislike most about chemsex?

What do I like most about sober sex?

What do I dislike most about sober sex?

Goal 4: Take a short break from chems.[19] Suggesting a short break from chems can be the most practical and most effective way to support patients to make changes in the contexts of a sexual health presentation.

Firstly, a patient is invited to choose a period of time to be abstinent from chems and chemsex. (This goal can include or exclude alcohol, or clubbing drugs like ecstasy, as the patient chooses.) This may be for a period of 7 days, 2 weeks, 2 or 3 months or even just 2 days if the patient is using every day, and wanting a more manageable goal.

Once a period of time is chosen, the person is asked how confident they are that they can achieve this goal – perhaps on a scale of 1 to 10. If the person does not feel very confident about achieving this goal, it may be that they have been overly ambitious in their target. A small, achievable goal is preferable to a large, unachievable goal. It is preferable that a patient returns in 7 days as a success, having achieved their goal, than in 3 months feeling that they have failed having not achieved their goal. A sense of accomplishment is a significant motivator and confidence booster.

Once a time period is set (perhaps seven days) the patient is asked how important it is to them that they achieve this goal. Again, a scale of 1 to 10 can be used to gauge this. If the patient does not consider this goal to be important, they can be released from any further requirement to engage in this process. If they are doing this because a doctor, partner, parent or friend is telling them to do it, personal motivation is absent, and presents an obstacle.

However, this question serves another purpose: it is designed to make the person cognitive of their own motivation or lack thereof. Sometimes, just vocalizing this can kick-start stirrings of self-care.

Assuming that achieving this goal *is* important to a patient, the next step would be to prepare him for what to expect in the coming days of abstinence.

Triggers[22]**:** Identifying the moments over the next few days when a patient is most likely to be vulnerable to triggers or cravings, is crucial. A patient might identify that he is unlikely to be triggered on a Wednesday morning when preparing to go to work. He may find that he is unlikely to be triggered on a Thursday lunch time, eating with his colleagues. He may find that being home alone and bored while his friends are out clubbing, triggers difficult cravings. He may find that logging onto Grindr on the train home from dinner having had a few drinks makes him vulnerable to cravings. There may be other moments within this period that a patient might identify (or that we might identify for him). Being aware of these vulnerable moments can empower patients to be prepared for these trigger moments, and perhaps put supportive measures in place in anticipation of them. These might include inviting a trusted friend round, or arranging to spend time differently. There are many other circumstances, people, places and emotions that can trigger seemingly unmanageable cravings; a discussion with patients about events precipitating past chem-using episodes will help him to become more familiar with the triggers that are unique to him, helping him to be better prepared in the coming days.

Cravings[22]: Cravings can seemingly come on without warning, and can be overwhelming. But if a patient is are aware of his triggers, then the craving can be less of a surprise when it hits. Several techniques are available to support patients to better manage cravings when they occur.

Patients often describe a craving as an angel sitting on one shoulder, and a devil sitting on the other; both engaged in a cyclical dialogue about whether to use or not; a dialogue that is unresolvable. During the course of this dialogue, a patient will usually be (unknowingly) hyperventilating, highly anxious and disengaged from the events happening around him, as he tries in vain to resolve this decision "to use or not to use". However, response to a craving is not an intellectual decision; it is an emotional, anxious state. To resolve a craving, a patient must learn to overcome this emotional state. This can be done by controlling the breathing and thinking calming thoughts, for example, of pleasant experiences and taking steps to distract themselves from these cyclical unproductive thought processes. Calling a friend can help, opening a window, changing the lighting or music, going for a walk while continuing to breathe deeply. A craving is manageable, and it can take some practice to master. The solution is to change the emotional state one is in. There is a wealth of craving management techniques online that are available for patients to be directed to[23].

Box 4: The Chemsex Care Plan

In the space of 15 or 20 minutes, in the same setting in which the sexual health consultation takes place, we have guided our patient through some practical steps to spend the coming days differently

- he has chosen a goal of seven days without chems
- he feels confident he can achieve this practical and realistic goal
- he has told us it's important to him to achieve this goal. That's a powerful disclosure
- he has indentified the times within the next seven days that he is most vulnerable to cravings, and put things in place to support him during those times
- he has, with the clinician's help, identified the triggers that are most likely to bring on cravings
- he has also identified some things he can do differently next time he has a craving, to help him manage the emotion differently (rather than acting on it)
- he has a seven day care plan

This care plan can be followed up in seven days time; if it was too easy for the patient, a more challenging goal can be chosen. If it was too difficult for the patient, and lapses occurred, then a smaller goal can be attempted. It may take time for people to become adept at identifying triggers and averting cravings effectively, so lapses are to be expected, and should be seen as learning opportunities, not failures. When consistent lapses occur, or chem use is more problematic, other potential referrals/interventions should be considered.

A clinician feeling unskilled to have this conversation can use the online tool as a guide.[6] It should be noted that this tool is not a one size fits all device but is extremely useful in enabling clinicians to intervene relatively early in a behaviour that has the potential to spiral into more problematic use and that contributes significantly rising STI rates and sexual ill

health. It also enables clinicians to intervene in a way that empowers patients to be more conscious and reflective about their own health and choices.

Conclusion

Chemsex is undoubtedly a challenging issue for both patients and professionals in sexual health services.

It is associated with behaviours that are linked to an increased risk of HIV acquisition e.g. condomless sex; multiple partners; fisting/and use of sex toys

Addictive behaviours can be very difficult to understand and manage, particularly when linked to a culture of normalised drug use within communities and online networks and combined with complex psychosexual/psychosocial issues related to sex and intimacy.

Sexual health settings may not instinctively be the most likely settings for provision of chemsex support; however, given that these services witness the brunt of the consequences of this behaviour, with appropriate training and resources, arguably they are in fact, in a good position to provide this.

References

1. Stuart D, Weymann J. Chemsex and care planning: one year in practice. *HIV Nurs* 2015;15:24–8

2. McCall et al. What is Chemsex and why does it matter? *BMJ* 2015;351:h5790

3. Johnson B. Addiction and Will. *Front Hum Neurosci* 2013;7:545. doi:10.3389/fnhum.2013.00545.5

4. Lundahl B, Burke B. L. The effectiveness and applicability of motivational interviewing: a practice-friendly review of four meta-analyses. *J. Clin. Psychol* 2009;65: 1232–1245. doi:10.1002/jclp.20638

5. Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioural domains: a systematic review. *Addiction* 2001;96:1725–42

6. Stuart D. ChemSex Care Plan 2011. Available at: http://www.davidstuart.org/care-plan (accessed July 2017)

7. 56 Dean Street. ChemSex screening tool, 2015. Available at: http://dean.st/wp-content/uploads/sites/11/2016/06/ChemSex-screening-tool-and-risk-assessment-GUM.pdf (accessed July 2017)

8. Bracchi M et al. Increasing use of 'party drugs' in people living with HIV on antiretrovirals: a concern for patient safety. AIDS 2015;29: 1585-1592

9. Stuart D. Chem Sex Toolkit for GUM/HIV staff. Sexualised drug use by MSM (ChemSex): a toolkit for GUM/HIV staff. *HIV Nursing* 2014;14:15

10. Stuart D. Harm reduction, 2011. Available at: http://www.davidstuart.org/playsafe (accessed July 2017).

11. Chelsea and Westminster hospital. Chemsex and hepatitis C; A guide for clinicians, 2014. Available at http://www.chelwest.nhs.uk/services/hiv-sexual-health/professionals/links/ChemSex-Hep-C-Guide.pdf (accessed July 2017)

12. McFaul K, Maghlaoui A , Nzuruba M, et al. Acute hepatitis C infection in HIV-negative men who have sex with men. *J Viral Hepat* 2015;535-538

13. Men R Us. Safer Injecting. Available at: https://www.menrus.co.uk/drugs-content/safer-injecting/ (accessed July 2017).

14. London Friend. Apps, dating and personal safety, 2015. Available at: http://londonfriend.org.uk/get-support/drugsandalcohol/apps-dating-sites/ (accessed July 2017).

15. London Friend. Drug and alcohol harm reduction tips. Available at: http://londonfriend.org.uk/get-support/drugsandalcohol/info-for-playing-safely/ (accessed July 2017).

16. GMFA. Safer Chems, 2013. Available at: https://www.gmfa.org.uk/saferchems-chems (accessed July 2017).

17. 56 Dean Street. ChemSex support , 2015. Available at: http://dean.st/chemsex-support/ (accessed July 2017).

18. Stuart D. Abstinence, 2011. Available at: http://www.davidstuart.org/abstinence1 (accessed July 2017).

19. Stuart D. Take a break, 2011. Available at: http://www.davidstuart.org/take-a-break (accessed July 2017).

20. Stuart D. Ambivalence, 2011. Available at: http://www.davidstuart.org/thinking (accessed July 2017).

21. Stuart D. Reflective questions, 2011. Available at: http://www.davidstuart.org/thinking (accessed July 2017).

22. Stuart D. Triggers, 2011. Available at: http://www.davidstuart.org/triggers (accessed July 2017).

23. 56 Dean Street Official YouTube playlist. Chems Support, 2014. Available at: https://www.youtube.com/playlist?list=PLsi7TLi2MKjbyGp99AmNsB5ZJhquyrdu- (accessed July 2017).