

How to assess gay, bisexual and other men who have sex with men for chemsex

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ABSTRACT

Objectives Sexualised substance use, 'chemsex', is being increasingly reported by gay, bisexual and other men who have sex with men (GBMSM) in sexual health clinics. We aim to describe the evidence base and practical ways in which clinicians can assess and advise patients disclosing chemsex.

Methods We review published literature on chemsex, discuss vulnerability to substance use, highlight the importance of clinical communication and discuss a management approach.

Results GBMSM are vulnerable to substance use problems, which interplay with mental, physical and sexual health. Knowledge on sexualised drug use and related communication skills are essential to facilitating disclosure. Identifying sexual health and other consequences of harmful drug use may motivate patients to seek change.

Conclusions Sexual health clinicians are well placed to make more holistic assessments of GBMSM accessing their services to promote broader sexual health and well-being beyond the management of HIV and sexually transmitted infections (STIs) alone.

INTRODUCTION

The use of prescribed and other recreational drugs to enhance sexual performance is common in the UK and has been associated with condomless anal sex and recent diagnosis of sexually transmitted infections (STIs).^{1 2} 'Chemsex' is a more recently described phenomenon in gay, bisexual and other men who have sex with men (GBMSM), which describes the use of mephedrone, crystal methamphetamine, γ -hydroxybutyrate (GHB), γ -butyrolactone (GBL) and less commonly, cocaine and ketamine with sex.³ In recent years, there has been an exponential increase in GBMSM reporting chemsex participation and seeking support from designated drug and sexual health services.^{4 5} This article focuses on the clinical assessment and evaluation of GBMSM disclosing chemsex participation in sexual health settings.

There are limited UK data on the extent of chemsex-related consequences. Current evidence however suggests that sexualised methamphetamine use is associated with multiple partners, sexual risk-taking and increased rates of HIV, hepatitis C, other STIs and *Shigella flexneri* infections.⁶⁻⁹ Public Health England has identified the goal of decreasing the proportion of GBMSM reporting chemsex in its 2015-2016 action plan to improve the health and well-being of GBMSM.¹⁰

GBMSM indicated in a qualitative study that they are comfortable discussing chemsex in sexual health clinics.³ Sexual health clinicians therefore

should be skilled at facilitating disclosure and appropriately assessing patients. Clinicians should also be offering brief interventions, providing basic harm-reduction advice and signposting patients wanting help with a drug problem to appropriate services. Cultural and clinical competency is essential to facilitating disclosure. This requires understanding why some GBMSM may be vulnerable, the motivation for chemsex, the drugs used, the sexualised context and potential consequences.

UNDERSTANDING VULNERABILITY IN GBMSM

There is a triad of inequality in GBMSM health in the areas of sexual health, mental health and alcohol, substance and tobacco use.¹¹ These inequalities can be interrelated, offering UK sexual health clinics, already well accessed by GBMSM, a unique opportunity to provide more holistic assessments and targeted interventions.

A 2008 systematic review found that depression and anxiety disorders were more common in GBMSM. It also reported that gay and bisexual men were at higher risk of substance use and dependence than heterosexuals, with 50% higher rates of alcohol dependence seen in GBMSM.¹² One in four gay men surveyed for a UK study reported deliberate self-harm, compared with one in seven heterosexual men.¹³

Reasons for chemsex can be complex, and include seeking pleasure or prolonging sex sessions.³ Drugs are also used by some to facilitate intimacy, manage anxiety and low mood, ameliorate HIV stigma, overcome negative feelings of body image and as a way of self-harming.¹⁴ Negative attitudes about homosexuality can become incorporated into a person's sense of self, resulting in internalised heterosexism.¹⁵ Elevated rates of substance use may be linked to shame or stress associated with this identity-related self-stigma.¹⁶

CHEMSEX DRUGS AND SEXUALISED CONTEXT

Chemsex often occurs in private residences and sex parties sometimes described as 'chill outs,' which can at times occur over several days.¹ Access to these events is often facilitated by smartphone geo-spatial networking applications.

Table 1 lists common drugs used with chemsex, method of administration and the desired effects sought by users. Mephedrone and crystal methamphetamine are stimulants causing sexual arousal, euphoria as well as increasing heart rate and blood pressure. Crystal methamphetamine, bought in crystal form, is usually vaporised and smoked through a glass pipe or injected. It is a potent stimulant and is strongly associated with psychological dependence.¹⁷ Mephedrone is swallowed,



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Table 1 Main drugs used for chemsex

Name of drug and form	Common colloquial term	How it's taken	Desired effects
Mephedrone (white powder)	MCat, Meow meow, M, Drone	Ingested Snorted Injected Rectally	Euphoria Alertness Sexual arousal
GBL/GHB (clear liquid)	G	Ingested mixed in a drink	Euphoria Disinhibition Sexual arousal Drowsiness
Crystal methamphetamine (white powder or clear crystals)	Tina	Smoked in glass pipe Injected Rectally	Euphoria Alertness Sexual arousal

GBL, γ -butyrolactone; GHB, γ -hydroxybutyrate.

snorted or injected, and is also associated with psychological dependence. A psychologically dependent person may be unable to have sex or feel pleasure unless they are using substances.

GBL/GHB is usually diluted in a drink in 1–2 mL aliquots. Accidental overdose, either due to a cumulative effect of dosing too frequently, taking too high a dose or combining it with alcohol, can cause potentially life-threatening central nervous system and respiratory depression. Abrupt discontinuation after chronic use may result in a physical withdrawal syndrome not dissimilar to that seen with alcohol withdrawal. Specialist detoxification advice should be sought, and treatment with benzodiazepines is usually necessary.^{17 18}

There is also evidence to suggest that a proportion of men participating in chemsex are injecting drugs (colloquially referred to as ‘slamming’) which comes with additional harms.^{5 6} The Novel Psychoactive Treatment UK Network (NEPTUNE) has published a document providing guidance on the clinical management of acute intoxication and harmful and dependent use of these substances.¹⁷

Creating clinic environments where GBMSM feel safe is essential.¹⁹ Visible patient information leaflets about chemsex and posters can highlight sexual health clinics as safe places to discuss chemsex. Holistic assessments are already taking place for young people accessing sexual health services and similar assessments with structured pro formas which include specific questions about substance, alcohol and tobacco use, chemsex and mental health could be introduced to improve assessments of GBMSM (see online supplementary file 1).²⁰ Questionnaires may also be used to assess problematic chemsex and devise care plans tailored to particular patient needs.⁵ There are however no validated tools for evaluating chemsex in GBMSM, and further research is needed in this area.

CLINICAL COMMUNICATION

Patients attending a sexual health service may not necessarily expect to discuss drug use. Sensitive communication skills and non-judgemental attitudes are essential. It is also important to have an approach that recognises that not all patients disclosing chemsex necessarily have a problem that requires support or onward referral. Acknowledging that it can be a difficult area to discuss and outlining confidentiality policies and the reasons for questions may be helpful. Using a ‘signposting’ statement can help prepare a patient and facilitate disclosure, for example, ‘In order for me to recommend blood tests correctly, I will be

asking questions about drugs, including asking about taking drugs with sex’. A normalising statement about a behaviour that a patient may perceive as potentially eliciting disapproval from a healthcare worker can also be helpful in eliciting more honest disclosure, for example, ‘Some people find that when they have taken drugs, they can push boundaries or take risks when having sex’. Appropriate training on drugs, communication and cultural competency can improve staff confidence in addressing the issue.²¹

IDENTIFYING AND ASSESSING IMMEDIATE MEDICAL PRIORITIES

Clinical priorities such as offering postexposure prophylaxis (PEP) and hepatitis B vaccination should be addressed. Given the higher likelihood of GBMSM with HIV participating in chemsex,⁶ knowledge of antiretrovirals is essential in order to identify those at highest risk of drug-related resistance from intermittent adherence due to treatment breaks or to advise patients on potential drug interactions.²² Factors such as prolonged or traumatic sexual practices and injecting drug use should be taken into consideration when considering PEP or assessing for hepatitis C risk. In addition, a psychological assessment to ensure the patients are not at any immediate risk to themselves or others may be required.

HARM MINIMISATION DISCUSSION

Establishing patterns of drug use and administration may identify opportunities for minimising harm. Advice on needle exchange services and safer injecting practice is essential for those disclosing injecting drug use. Patients who snort drugs should also be advised on not sharing snorting paraphernalia. Similarly, it would be important to advise patients who administer drugs rectally using a needleless syringe (a practice referred to as ‘booty bumping’) not to share syringe barrels.

Factors that potentiate HIV and hepatitis C transmission,⁹ such as prolonged sex, sharing of lubricant containers or fisting, which can be associated with rectal tears should be discussed. Information on minimising *Shigella* risk should also be provided.⁷ Working with a patient to modify harmful drug-taking patterns may be an achievable goal for some patients, and this may be facilitated by the use of individualised care plans and support.⁵ There remains a lack of published evidence for chemsex-specific interventions, and there is an urgent need for research in this area.

ASSESSING CONSEQUENCES OF SEXUALISED SUBSTANCE USE

Physical health consequences may include accidental overdose, any drug-related hospital admission, STI diagnoses, HIV or hepatitis C acquisition or injection site infections such as thrombophlebitis or cellulitis. Some patients may experience dental complications including bruxism and caries with tooth loss.¹⁷ Patients may describe emotional lability or aggressive behaviour¹⁷ or risk-taking behaviours, for example, driving while intoxicated. Some patients have experienced concerns regarding sexual consent while under the influence of drugs.²³

Using validated tools for anxiety and depression assessment²⁴ can aid assessment, but drug use can mask or exacerbate symptoms of anxiety or depression. A screening question such as ‘When was the last time you had sex or had fun without the use of drugs?’ may aid reflection in a patient. Some patients may express feelings of guilt about the extent of chemsex or drug use, and others may have had concerns expressed from family, friends or healthcare professionals.

A person experiencing problematic drug use may become increasingly isolated with additional social consequences. These may include breakdown of relationships with partners or family or consequences to finances, housing or employment as well as legal problems. Inviting a patient to reflect on consequences may help motivate a patient with problematic sexualised substance use to consider making changes and accept onward referral.

FOLLOW-UP, REFERRAL AND LIAISON

GBMSM disclosing chemsex represent a vulnerable population, and clinics should consider proactive follow-up arrangements for these patients to encourage regular STI screening, including hepatitis C testing. Those with significant risk should be followed up closely because of clinical benefits to diagnosing both hepatitis C and HIV early.^{25 26} HIV clinics should integrate routine assessments of drug use and chemsex into existing care pathways for GBMSM.

Clinics should also be equipped to support patients with appropriately trained staff in motivational interviewing, which has been shown to improve entry to and engagement in more intensive substance use treatment.²⁷ The goals for a patient seeking to make changes will vary between different individuals. Specialist assessment by drug services can help identify goals, provide relapse prevention support and deal with underlying issues. Peer support through support groups (eg, Narcotics Anonymous or SMART Recovery) may be helpful for some. There is an urgent need for sexual health clinics to work collaboratively with drug services to develop and evaluate interventions. The involvement of patients and close working and joint training with local drug services are essential to addressing this emerging public health problem.

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REFERENCES

- Mitchell KR, Prah P, Mercer CH, *et al*. Medicated sex in Britain: evidence from the third National Survey of Sexual Attitudes and Lifestyles. *Sex Transm Infect* 2016;92:32–8.
- Li J, McDaid LM. Alcohol and drug use during unprotected anal intercourse among gay and bisexual men in Scotland: what are the implications for HIV prevention? *Sex Transm Infect* 2014;90:125–32.
- Bourne A, Reid D, Hickson F, *et al*. *The Chemsex study: drug use in sexual settings among gay and bisexual men in Lambeth*. Southwark & Lewisham, 2014.
- Moncrieff M. *Out of your mind: improving provision of drug and alcohol treatment for lesbian, gay, bisexual and trans people*. London: Friend, 2014.
- Stuart D, Weymann J. Chemsex and care planning: one year in practice. *HIV Nurs* 2015;15:24–8.
- Hegazi A, Lee M, Whittaker W, *et al*. Chemsex and the city: sexualised substance use in gay, bisexual and other men who have sex with men. *Internat J STD and AIDS*, 2016.
- Gilbart V, Simms I, Jenkins C, *et al*. Sex, drugs and smart phone applications: findings from semistructured interviews with men who have sex with men diagnosed with *Shigella flexneri* 3a in England and Wales. *Sex Transm Infect* 2015;91:598–602.
- Vosburgh HW, Mansergh G, Sullivan PS, *et al*. A review of the literature on event-level substance use and sexual risk behavior among men who have sex with men. *AIDS Behav* 2012;16:1394–410.
- Hagan H, Jordan AE, Neurer J, *et al*. Incidence of sexually transmitted hepatitis C virus infection in HIV-positive men who have sex with men. *AIDS* 2015;29:2335–45.
- Justin Varney LG, Watson S, Makurah L, *et al*. *Public Health England action plan: promoting the health of gay, bisexual and other men who have sex with men*. Public Health England, 2015.
- Draft Strategic framework to promote the health and wellbeing of gay, bisexual and other men who have sex with men*. Public Health England, 2014.
- King M, Semlyen J, Tai SS, *et al*. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008;8:70.
- King M, McKeown E, Warner J, *et al*. Mental health and quality of life of gay men and lesbians in England and Wales Controlled, cross-sectional study. *Br J Psychiatry* 2003;183:552–8.
- Keogh P, Reid D, Bourne A, *et al*. Wasted opportunities: problematic alcohol and drug use among gay men and bisexual men. 2009.
- Amadio DM. Internalized heterosexism, alcohol use, and alcohol-related problems among lesbians and gay men. *Addict Behav* 2006;31:1153–62.
- Hequembourg AL, Dearing RL. Exploring shame, guilt, and risky substance use among sexual minority men and women. *J Homosex* 2013;60:615–38.
- Abdulrahim D, Bowden-Jones O, on behalf of the NEPTUNE Expert Group. *Guidance on the clinical management of acute and chronic harms of club drugs and novel psychoactive substances*. NEPTUNE Expert Group, 2015.
- Schep LJ, Knudsen K, Slaughter RJ, *et al*. The clinical toxicology of gamma-hydroxybutyrate, gamma-butyrolactone and 1, 4-butanediol. *Clin Toxicol* 2012;50:458–70.
- Pennant ME, Bayliss SE, Meads CA. Improving lesbian, gay and bisexual healthcare: a systematic review of qualitative literature from the UK. *Diversity Health Care* 2009;6:193–203.
- Lee MJ, Oza B, Pakianathan M, *et al*. Making every contact count: improving the assessment of gay, bisexual and other men who have sex with men using a structured proforma. *Sex Transm Infect* 2016;92:48.
- Brown MP, Pakianathan MR, Lobb-Rossini J, Turner M. Talking about Chemsex—a collaboration between medical school and hospital. *International Conference on Communications in Healthcare*; New Orleans, USA, 2015.
- Bracchi M, Stuart D, Castles R, *et al*. Increasing use of 'party drugs' in people living with HIV on antiretrovirals: a concern for patient safety. *AIDS* 2015;29:1585–92.
- Bourne A, Reid D, Hickson F, *et al*. "Chemsex" and harm reduction need among gay men in South London. *Int J Drug Policy* 2015;26:1171–6.
- Pilling S, Anderson I, Goldberg D, *et al*. Depression in adults, including those with a chronic physical health problem: summary of NICE guidance. *BMJ* 2009;339:b4108.
- Koretz RL, Lin KW, Ioannidis JP, *et al*. Is widespread screening for hepatitis C justified? *BMJ* 2015;350:g7809.
- Girardi E, Sabin CA, Antonella d'Arminio Monforte M. Late diagnosis of HIV infection: epidemiological features, consequences and strategies to encourage earlier testing. *J Acquir Immune Defic Syndr* 2007;46:S3–8.
- Dunn C, Deroo L, Rivara FP. The use of brief interventions adapted from motivational interviewing across behavioral domains: a systematic review. *Addiction* 2001;96:1725–42.



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