

Symposium report

MSM, drug use and sexual behaviour

Hosted by CHAPS/Terrence Higgins Trust (THT) and the Centre for Research on Drugs and Health Behaviour (CRDHB)

Drug use among men who have sex with men (MSM) in the UK is much higher than among the general population, particularly among those with a large number of sexual partners and those who are HIV positive. Evidence suggests that MSM who use particular illicit drugs (as well as alcohol) are more likely to engage in risky sexual behaviours and that among men who do use substances, sexual acts accompanied by substance use are more likely to involve sexual risk than acts not involving substance use.

As current national strategies omit substance use among MSM and some evidence suggests that drug and alcohol treatment services do not adequately address gay men's substance use, there is a need to develop health promotion interventions to address these behaviours in this population and to improve the accessibility and appropriateness for MSM of existing drug treatment services.

CHAPS and THT commissioned this symposium to bring together experts in the field of research on drug use among MSM to discuss the current state of the evidence and to highlight ways forward for health promotion research, practice and policy.

Aim of the symposium

CHAPS/THT and CRDHB jointly hosted a one-day symposium for over 20 health

promotion researchers and practitioners at LSHTM to discuss the current evidence regarding drug use and risky sexual behaviour among MSM, and outline recommendations for the development of health promotion interventions to address substance use and sexual behaviour in this population.

This document is a summary of the presentations and discussions at the symposium.

Presentations

Drug use among gay men in the UK: findings from the Gay Men's Sex Survey'

Chris Bonell, CRDHB, LSHTM (Co-authors: Ford Hickson, Peter Weatherburn and David Reid)

When comparing sexual risk among drug-using and non-using men, any

reported associations between drug use and sexual risk are likely to be confounded by an individual's overall orientation to risk. Research should instead examine whether risk is higher in sex acts accompanied versus not accompanied by drug use (drawing on reports of multiple sex acts from each man surveyed). Although this evidence is prone to some remaining confounding it is nonetheless stronger.

Such studies include a 2004 US study of HIV negative MSM, which found an association between sero-discordant unprotected anal (UAI) sex and the use of alcohol, volatile nitrates, amphetamine and cocaine – though not cannabis, hallucinogens, crack or heroin. Another US study published in 2006 found an association between UAI among men recently diagnosed with HIV and use of methamphetamine, cannabis and Viagra. This association was not

found for nitrates or GHB.

There are no such studies from the UK. However, informed by the above studies it is likely that, rather than there being one single drug which uniquely 'causes' sexual risk behaviour, most drugs as well as alcohol are associated with some degree of increased sexual risk. Furthermore, the drugs that are likely to contribute most to the overall rate of sexual risk behaviour and HIV transmission are likely to be those that are most commonly used.

Evidence on which drugs are most commonly used can be drawn from the UK Gay Men's Sex Survey (GMSS), run by Sigma since 1993. The samples from recent surveys are broadly representative of the UK population of MSM in terms of age, education, ethnicity, residence and HIV testing but somewhat over-represent men most engaged in sexual risk.

Data from the GMSS 1999, 2005 and 2007 illustrate some trends in substance use among gay men in the UK. There has been an increase in 'club' drugs such as ecstasy, cocaine and ketamine which may now be levelling off. Respectively, 24%, 22% and 13% of men in 2005 reported use in the previous year of ecstasy, cocaine and ketamine. Similarly, 44%, 32%, and 9% of men in 2005 reported use in the previous year of poppers, cannabis and amphetamine.

In 2005 drug use was more common among men aged 15-34, living in London, with more partners, diagnosed with HIV, and of white ethnicity.

Data from 2007 illustrates the frequency of drug use. Some drugs are used more often, e.g. nitrates and cannabis than other, e.g. cocaine and amphetamine. Poly-drug use (using more than one drug in the previous year) is common.

Data from 2007 also show that although methamphetamine use is more common in London (8%), use may be increasing in other areas (2-3%).

Methamphetamine use is higher among men diagnosed with HIV, between the ages of 30-49, and with 5 or more partners in the past year.

Conclusions:

- Substance use is likely to be associated with sexual risk and rather than one drug being key, various substances are likely to be associated with increased risk.
- Drug use is more prevalent among MSM than other groups, and MSM use some drugs, e.g. cannabis, ecstasy, cocaine and nitrates, more than others.
- The increase in use of 'club drugs' may be peaking.
- There is higher drug use in London, among HIV-diagnosed men, men reporting more partners, among white men and among young men.
- There is some meth use in the UK. This is more common within London, but not insubstantial elsewhere.

Recommendations:

- Health promotion should address drug use as an influence on sexual risk and should focus on those drugs most commonly used (including illicit drugs as well as alcohol).

Points arising from the floor in discussion:

- Clinically, men with nitrite problems in their early 20s and 30s present with hemoglobinemia - explain and with 'poppers' related burns from extensive sniffing.
- There are potential differences in how different drugs are used by age and this will have implications for the problems people present with when seeking medical attention.

- There has been an increase in media interest in meth as a result of a paper by Graham Bolding et al.
- Crystal MDMA is increasing in popularity as it is crystalised. There is some anecdotal evidence that people tend to think that anything crystal is better quality.
- Problematic drug use (PDU) regarding meth may rise. Increasing numbers of clients are presenting to drug treatment centres with problems with using meth. In 2004, the number of people presenting was minimal, now about 20% of clients at one drug treatment centre - which drug treatment centre use meth. There had been a particular increase in the past 3-4 years.
- Some explanation for why generic drug treatment facilities may not be accessed by gay men is that may be thought to be for 'hard core' drug use, such as heroin users.
- It is not clear whether it is sexual orientation or the type of drug use that may deter MSM using drug treatment services; it may be both.
- Gay men may not feel comfortable discussing their use of drugs during sexual behaviour within generic drug services.

Wasted opportunities: problematic drug use & alcohol use among MSM

Dr. Adam Bourne, Sigma Research

Wasted opportunities is a qualitative study including 40 interviews with gay and bisexual men who self-identified as having an alcohol and/or drug use problem. Men completing the Gay Men's Sex Survey in 2007 were shown a list of drugs and asked whether they ever used them, whether they had used them in the last 12 months used drugs and whether they were worried about this substance use. The 40 men interviewed

represent a sample of those who reported worry about their substance use. The interviews covered their history of substance use, their perceptions of the problem, strategies they have used to eliminate or minimise harm, intervention and service needs, and experiences of interventions and service use.

Reasons reported for using drugs and alcohol largely surrounded dealing with different types of unease. For example some men reported using ecstasy to deal with 'social unease', for example allowing him to party all night, to relax, and to gain confidence to enter gay social spaces which some considered quite anxiety provoking. Using substances was often described as a social lubricant, helping with confidence particularly among younger men and men living with HIV. It was also described as helping with sexual unease, negotiation and intimacy. For example, some men described needing 'Dutch courage' to approach another man in a bar. Using substances was reported as giving people confidence take part in sexual practices that they always wanted to but found difficult to try.

Using substances was also described as a mechanism for dealing with negative feelings. For example:

- using drugs to 'escape' and to cope
- to help forget about worries or concerns
- deal with loneliness or isolation – mostly with HIV+ and also those living in rural areas
- dealing with unease related to sexuality.

Substance use was also described as a way with fitting into existing cultures. For example, men who moved from small towns/areas to cities such as London and Manchester described using substances to 'fit in'. Most gay venues

centre on alcohol and, possibly, drug use. Some men were not sure where to meet other men outside of this context.

The interviews also covered harms associated with the use of alcohol and drugs. Significant harms to physical and mental harm were described by nearly all of the men, while men living with HIV worried about use of drugs and alcohol and the effectiveness of their HAART therapy. There were also impacts upon social and personal well-being. Some respondents reported an awareness of the time and money wasted while coming down from drug use. Some said they would like to spend more time doing more enriching things that do not involve substance use. Drug and alcohol use was also said to have an impact on their ability to perform at work.

There was some discussion of the harms to sexual health and wellbeing from alcohol and drug use. Respondents reported:

- not having fulfilling sex lives. Not having sex they wanted or enjoyed
- choosing to do things sexually that they later regretted
- HIV transmission risk behaviour is more likely when using alcohol and drugs (eg, Ecstasy).

Some respondents discussed their efforts to managing use and seek help. Some avoided going to places or situations where drug use was occurring but this was difficult because many gay venues are locations where alcohol and often drug use are prevalent. Some sought help on their own, while others reported that friends or family members had intervened to get them the help they felt was needed. There were challenges, though with sourcing appropriate help as some men had either experienced substance use services that were not respectful of their sexuality, or were

concerned that services might not understand the social and/or sexual context of their substance use.

Conclusions:

- All of the men interviewed felt that their use was problematic, but the way in which they felt it was problematic differed.
- Only a small number of men considered that they had a chemical dependency on drugs.
- Alcohol and drug use is reinforced within the cultural norms of the gay community that, to a large extent, exists only in and around premises that serve alcohol or where men take drugs.
- There is a need for services that take into account the particular social and cultural circumstances of gay and bisexual men.

Points arising from the floor in discussion:

- Generic drugs treatment services do not meet the needs of gay men who use drugs for the above reasons. There is a need more services targeted to MSM.
- Providers of generic drug treatment tend not to consider the particular circumstances for drug use among MSM. Though providers would like to offer a comprehensive, all inclusive service, they are aware that they do not have the skills and are in need of more support.
- The national policy frame work focuses on needs related to ethnicity, crime, rough sleeping, and families.
- There is a disincentive to treat recreational drug users as funding is mostly available for the treatment of PDUs. This approach may indirectly discriminate against gay men.
- GUM and HIV treatment services can be better equipped to deal with recreational drug use for MSM and

others. These locations may be more acceptable to gay men as anecdotal evidence suggests that MSM prefer not to talk about their sexual behaviour in generic drug treatment services. As a result, they are short of places to discuss this.

- Further evidence is needed about how MSM view the services offered for drug use and sexual health and about the specific barriers to using drug treatment.
- Research has not yet established whether there is a causal relationship between drug use and sexual behaviour. Though evidence certainly suggests an association.
- In future work, there is a need to focus on the public health need and the health consequences of substance use and sexual behaviour.
- Reducing overall use in the population will have benefits not just for those at highest risk, but also for those at more marginal risk. There is a need to challenge the normative nature of drug and alcohol use in the gay community and explore the possibility of highlighting non-substance related activities to gay and bisexual men.

Acute recreational drug toxicity

Dr. Paul Dargan and Dr. David Wood, Guy's and St Thomas' NHS Foundation Trust

Guy's and St Thomas' offer both an outpatient and an inpatient specialist toxicology service. Approximately 40% of the cases seen in the inpatient service are related to acute recreational drug toxicity. Guy's and St Thomas' Clinical Toxicology and Emergency Departments are part of a collaborative project in the Vauxhall area of south London working with the Metropolitan Police, club owners/promoters/workers, and St. George's, University of London to

improve the 'pre-hospital' management of individuals with recreational drug toxicity, collect data on acute recreational drug toxicity and develop educational initiatives for both the public (users and their friends) and venue staff. Patients presenting to hospital for acute recreational drug toxicity have most often used cocaine and GHB/GBL. GBL use increased when it was classified. There has been an increase in the number of individuals presenting with GHB/GBL withdrawal, with some severe cases have required admission to ICU. Currently, there are limited provision for long-term support and follow-up not only for those presenting with acute GHB/GBL withdrawal, but also for those with problem recreational drug use.

Increasingly they are seeing toxicity from use of 'legal highs'. Over the last year there have been approximately, 40-50 of cases of acute mephedrone (and related cathinones) toxicity at their specialist service. During 2007/8 toxicity related to the piperazine drugs such as benzylpiperazine was seen.

The symptoms of acute recreational drug toxicity vary depending on the drug's main effect. For example, depressant drugs, such as GHB/GBL, 1,4-butanediol and opioids such as heroin and opium, after an initial high lead to agitation, sleepiness and vomiting. Constricted pupils are seen with opioids. Individuals who have used a depressant are often difficult to 'wake up' and in severe cases coma and respiratory depression occur. These symptoms are important as they can lead to aspiration of vomit, and in severe cases respiratory arrest (stopping breathing) and death. In small, but clinically significant minority of presentations for acute toxicity due to use of depressants result in the need for 24 hour ICU admission, which represents

a significant use of services.

The use of hallucinogenic drugs (eg, LSD, Ketamine, Glaucine and TFMPP) generally does cause acute life threatening symptoms, but the effects of the drugs can cause people to harm themselves due to visual or auditory hallucinations, and altered sense of reality, feelings of persecution and paranoia. These symptoms on their own can be uncomfortable for the individual and tend not to cause any acute medical harm.

The effects of stimulants such as MDMA (ecstasy), amphetamine, cocaine, 1-benzylpiperazine and mephedrone, are hyper-activity, chattiness, anxiety, agitation, bruxism (teeth grinding) sweating and dilated pupils. Severe complications related to use of stimulants include severe agitation, seizures, hypertension, heart attack (mostly due to cocaine use) and hyper-pyrexia. Hyper-pyrexia is increased body temperature. A temperature of more than 39-40 degrees requires urgent management in hospital as there is a risk of secondary organ damage and death.

The patterns of novel recreational drug use changes rapidly over time. For example, cathinones became prevalent only 6-12 months ago and mephedrone has increased in use among the nightclub and general population in the last 6 months. Therefore, the mapping and description of patterns of acute harm is not complete. The supply of novel recreational drugs is different from other recreational drugs, as they can often be purchased legitimately online. In the last 3 years the Guy's and St Thomas' Clinical Toxicology service, working with colleagues at St George's, University of London, have detected the following novel drugs in patients presenting to the Emergency

Department with acute recreational drug toxicity:

- 1-benzylpiperazine (BZP), m-chlorophenylpiperazine (mCPP), 3-trifluoromethylphenylpiperazine (TFMPP)
- 4-methylmethcathinone (mephedrone), 3-fluoro-methcathinone
- Bromo-dragonFLY
- Glauicine
- Diphenyl-2-pyrrolidinemethanol (D2PM)
- 2,5 – dimethoxy-4-chloroamphetamine (DOC).

The clinical effects and management of novel recreational drugs are broadly similar to classical recreational drugs and they cause either stimulant (eg, mephedrone, BZP, D2PM, DOC) or hallucinogenic (e.g. TFMPP, glauicine) effects.

In 2005, Guy's and St Thomas' Clinical Toxicology and Emergency Departments noted a delay in individuals being referred to hospital following significant recreational drug toxicity. In response, they developed guidelines for pre-hospital assessment and triage for use in clubs/venues in the Vauxhall south London area to allow 'club medic' staff to identify individuals for whom they should call an ambulance. These guidelines were piloted in the Vauxhall area in 2006/7 and then published and disseminated in 2008. Safer NightLife is a London Drug Policy Forum/Home Office document that provides advice and guidance to help ensure the health and safety of individuals in nightclubs and bars with a particular emphasis on those who also take drugs. The guidance covers a range of key issues, including creating a safe physical environment, tackling drug dealing, reducing harm from drug use and promoting sexual health. The ambulance referral guidelines were included in Safer

Nightlife together with information on the acute toxicity of recreational drugs and guidelines on facilities for club medical facilities.

The Clinical Toxicology service, along with their partners in the local area, felt that there were some gaps in recreational drug education and awareness amongst users and their friends:

- It is important that users and their friends are aware of what to do if someone develops recreational drug toxicity.
- Information on recreational drug use is not always readily available in a user friendly and non-confrontational format.

To try to address these gaps, the group developed a novel educational package known as 'Drug Idle'. This is an educational outreach event targeted to clinical and analytical toxicologists, the Metropolitan Police, and club owners and promoters. It has been run in Vauxhall previously, as there a large number of clubs/late night venues in this area and it is the location of the collaborative project. To date, the events have been attended by over 150 people, and the educational package has been developed and refined based on the feedback from those attending. It includes an interactive quiz, a breakout training session teaching how to put an individual into the recovery position and an 'ask the panel' session to allow individuals the opportunity to get expert opinion and advice on recreational drug issues. So far there have been four Drug Idle events and there are plans to take the event to Soho and outside MSM population.

Conclusions:

- Collaboration between clinicians and those working in the night-time environment can help to reduce harm

from recreational drug use and facilitate research in acute recreational drug harm and drug use epidemiology.

- Information offered to those using drugs needs to be tailored in a format appropriate for them.
- It is unclear whether this collaborative model would work elsewhere, among other demographic populations, although there is the potential to build on this collaborative working in different areas and with different populations, adapting the work as necessary to meet the needs of these areas/populations.

Points arising from the floor in discussion:

- The funding for the collaboration came from a number of sources, including the Department of Health. The Drug Idle events were in part funded through these sources and in addition there were contributions from the Metropolitan Police, nightclubs and local venues, QX magazine and Prowler.
- There has been substantial interest and involvement from nightclubs and venues, and as a result some owners and promoters are co- authors on a number of academic papers published from this work.

MSM, Drug Use and Sexual Behaviour: Overview of services and interventions in England

Gordon Mundie, Groupwork Coordinator, Terrence Higgins Trust (THT)

Terrence Higgins Trust has developed a number of interventions and services for MSM regarding recreational drug use. For example, 'Drugfucked', launched in May 2008, is a multi-faceted national campaign based on the results from the GMSS relating to MSM, drug use and sexual risk. It included a mass media

campaign in six magazines from May 2008 to July 2008 and small A5 leaflets describing 12 different drugs. The leaflets included information on the effects of drug use, the impact that they have on HIV medication, and information on where to locate counselling and outreach services. In addition to this, the campaign included sector development training courses, 1-to-1 counselling sessions and a dedicated website –

www.tht.org.uk/drugfucked with a function to talk to an HIV Drugs and Alcohol Counsellor – 'Talk to Steve'.

In collaboration with the Pan-London HIV Prevention Programme, in April 2008, 'Are you losing control?' was launched. It was an 8 week programme for gay men who felt that they had lost control of their relationship with drugs and/or alcohol. The programme explores their reasons for drug use and is not an abstinence programme. 'Are you losing control?' is currently oversubscribed.

Hard Cell, launched in 2007, was targeted toward men who engage in more 'kinky' sex. The website and leaflets discuss the impact drug use may have on sex. In 2005, THT launched a media campaign on drugs and sex through Boyz and QX magazines before extent of problem was fully understood. A further campaign in 2008, based on data from GMSS, addressed the use of poppers. The campaign included small packets of cola bottle sweets which were used to start conversations in an outreach setting which explained the different effects poppers can have.

The Gay Men's Health Charity, GMFA, has partnered with THT in producing sex, HIV prevention and drug use dedicated pages on the GMFA website. Additionally, the LGBT Party Safe website in Brighton, East and West Sussex provides information on drug use

and sex. PACE, an organisation specialising on counselling and support for LGBTs runs a weekly support group called 'Risky Business' in Soho that is open to gay and bisexual men identifying as PDUs.

A search of the 'NHS Choices' website located a dedicated interactive webpage under a section for gay men. The website signposts to local services, but does not list THT or other relevant organisations. There is also a section of the men's sexual health page for Wiltshire and Swindon that signpost to 12 drug treatment services available in the area.

Turning Point, Hungerford Drug Project runs a self-referral LGBT service called Antidote in London that provides counselling, weekly drop-in and complementary therapies for drug use. Antidote has only one paid worker and team of volunteers. Funding for this service is limited funding, though it treats a large number of clients. It appears to be one of few services that MSM report being comfortable attending, though some services are ending due to lack of funding.

Safer Portsmouth offers an online resource for the LGBT community with a dedicated drugs and alcohol service linked to the 'Save Dave' campaign. They provide support to anyone the age of 16 with issues with alcohol. The Armistead Centre in Liverpool offers support services for LGBT drug users and their families. There is both a drug surgery and a safe steroid use drop-in available, in addition to counselling.

Many localised services are available that do not have dedicated websites. These are typically signposted through acute care for social enterprises. NHS Trusts and police forces often work together to provide more targeted

support for MSM and drug use. CHAPS networks 'Drugfucked' across drug and alcohol services.

Points arising from the floor in discussion:

- The search for these services raised a number of issues about how availability of services is made known to MSM. Research conducted by Sigma suggests that MSM tend to go to the web for health information. There is currently no formal outreach work being conducted in this area. However, there is some concern that limited resourced and oversubscribed services create a disincentive to publicise interventions.

Part of the picture – The National Drug and Alcohol Database

Sara Ashworth, Drug and Alcohol Research Officer, Lesbian and Gay Foundation (Manchester)

Previous research has shown that gay men use recreational drugs at higher levels and for longer than heterosexual men and that lesbian and bisexual women use alcohol at higher levels than heterosexual women. However, providers at generic drug and alcohol treatment services are generally not aware of this and are not sensitive to the specific needs of the LGBT population.

The Lesbian and Gay Foundation have been jointly funded, along with the International School for Communities Rights and Inclusion at the University of Lancashire, to carry out a survey of drug and alcohol use among lesbian, gay and bisexual communities. The research is funded by The Big Lottery Research Programme and is the first of its kind in England. It is a five year project that is currently in its second year. The results of the survey will be used to build a database to help identify patterns of

use, dependency and access to services in LGB communities.

The survey is distributed as a self-completion questionnaire (mostly distributed at Pride events), an online survey, an interviewer led survey and a postal survey. So far the survey has had about 1500 responses, overall, but it is not yet representative of the English population. Currently, the older LGB community, black minority ethnic groups and religious groups are under-represented. This is expected to change as the sample size and composition changes.

Some preliminary analyses of data from respondents who reported drug use (n~800) suggest that one-fifth of respondents say that they would not ask for help for their drug use.

Points arising from the floor in discussion:

- The reported increase in use of cannabis maybe because it is used to 'come down' off of recreational drugs that are stimulants.

MSM, Drug use and sexual behaviour: A treatment provider perspective

Monty Moncrieff, Drug and alcohol treatment provider, Antidote

Antidote is a LGBT-specific drug and alcohol treatment service. It is part of wider Hungerford Project and offers service related to harm reduction, information, advice, keywork, counselling, group-work, and complementary therapies. After September funding will for the service will, unfortunately, end.

The service has observed some trends and shifts in drug use by MSM. There has been movement from dancing 'club' drug to drugs for sexual use. Related to this, there has been movement from

dance clubs to sex parties and saunas. There has also been a shift from ecstasy and ketamine use to GBL and crystal. Also, there is an increase in the practice of injecting or 'slamming' crystal and its concerns. Finally, the service has observed an increase in steroid use but this may have resulted from a recent targeted service.

Some data on trends from 2004-2009 show that meth use has increased from 0% to one-fifth of clients in 5 years.

The service has also observed a 'sexualising of drug use'. For example:

- Internet pages advertising for sex and drug use (party and play)
- sex workers ask or offer drugs
- scene magazines portray the clubbing lifestyle
- an increase in the prevalence of 'bareback' porn
- 'new' drugs used for sex
- an increase in the non-prescription use of viagra.

Some of the issues MSM present to the treatment service with include recreation becoming problematic, sexual drug use getting beyond their control, an increase in the practice of riskier activities, drug use beginning to impact upon employment, relationships, emotional well-being and physical well-being, an inability to stop using and withdrawal symptoms.

Some of the underlying reasons for drug use have to do with identity and 'how to be a gay man'. It is also connected to self-esteem, personal confidence, sexual confidence and body image.

The unmet need identified by the service includes:

- increased presentation of daily, dependent GBL use
- sangerous unsupervised detox – similar to that f alcohol withdrawal
- a need for impatient detox.

A referral pathway for GBL detoxification exists via South London & The Maudsley NHS Foundation Trust (SLAM) although if a client is not from their catchment boroughs referral can be complicated, requiring agreement of funding from the borough of residence or referral via existing, less-experienced, local pathways.

Some of the feedback from clients at Antidote suggest that clients choose a LGBT-specific service because they feel more confident discussing their lifestyle in the context. Mainstream services tend not to address the issues or needs for this group. The current commissioning structure does not support targeted work for LGBT, as funding is primarily for opiate and crack users (PDUs = Problematic Drug Users), which does not reflect the usual patterns of drug use by this group. Project LSD received HIV funding for targeted work with LGBT in the 1990s, but this funding ended and the project was taken over by Hungerford. There is substantial investment from criminal justice for drug treatment services, but it is largely for opiate and crack use and for PDU.

Efforts to raise the profile for MSM drug use treatment should work to add it to the central strategic agenda and work with the Home Office broaden the definition of PDU. The Home Office Diversity Working Group would be interested in some of the evidence coming out of the symposium. UK Drug Commission is presenting diversity research evidence to the Home Office which includes LGBT communities.

Points arising from the floor in discussion:

- How is London different to elsewhere in terms of GBL and crystal use? Evidence is need from areas outside of London. It is possible that the prevalence of use will spread outside

of London, but London holds the highest population of LGBT.

- The GMSS data suggests that very few people are using meth in the northwest.
- Meth was first introduced by people coming to London from USA and Australia. Newer immigrant communities might change patterns of use.
- Evidence also suggests that men are using crystal meth not in clubs but at home for sex.
- There is a need to reach out to sites like Gaydar or work with THT to disseminate information. Gaydar is not only used for sex it is also used for information on sexual health and HIV, especially in location outside of London.
- Magazines may also be good places for health promotion intervention and campaigns.
- It will be important to discuss the public health importance and sexual health importance of this issue to get it onto the Home Office agenda.

Points arising from group discussion

What do we know about drug use among MSM in England and its health consequences?

- MSM use alcohol and drugs more than the overall population.
- Substances such as alcohol, cannabis and poppers are the most commonly used drugs.
- Use of club drugs, such as ecstasy, cocaine and ketamine, rose over the last two decades, but now appears to have stabilised. Using recreational drugs is culturally accepted on the gay 'scene'. Alcohol use is the most prevalent, but often overlooked. Most people who use recreational drugs are poly drug users, either using different

drugs together at the same time or using different drugs on different occasions. Evidence from the USA suggests drug use, including use of alcohol, cannabis and poppers, is associated with increased sexual risk-taking behaviour.

- At the population level, it is likely that the more commonly used drugs are more influential on overall levels of sexual risk behaviour and HIV transmission than are less commonly used drugs.
- For the evidence that is available we need to construct a strategy for pulling it all together. This may make this story more compelling for commissioners, more specific and more targeted.
- The focus, and evidence, tends to be on London, but it is not clear whether these issues are prevalent elsewhere.
- Also, are the data we have representative of the target population? GMSS is a nationally representative survey, but there are challenges with collecting these data as drug use is a criminal activity and some potential respondents worry about the stigma associated with certain related sexual behaviours.
- Point of service has limited capacity to address issues relevant for MSM. Many MSM are not aware of the services that are available to them and view generic services as primarily for IVDUs, including drug treatment services.

What does this suggest that we need to do as health promoters?

- Health promoters can aim to reduce overall rates of substance use and to enable men to manage associated risks via enabling rather than directive interventions.
- Health promoters can also aim to address structural influences on substance use such as social norms

and the environment of gay commercial venues (eg, serving visibly drunk men, lack of seating to encourage 'vertical drinking', loud music).

- Although drug treatment services are important in addressing the physical and mental health harms associated with problematic drug use, they are unlikely to have much impact on rates of sexual risk behaviour or HIV transmission because more commonly used 'softer' substances are not regarded as problematic, despite their association with sexual risk-taking.
- The HIV services need to work more closely with those working within drug services, both at the service and at the policy level. Partnership working and collaboration appear to be important, but key stakeholders at national and local levels need to be identified.
- Other sectors that should be involved are – GUM, some gay GPs, senior level police, the Home Office.
- There is a strong case for expanding treatment services for recreational use for MSM with a focus on equality as the driver. Methamphetamine use has begun in the UK and has the potential to increase, though at the moment PDU of meth is actually quite low and not a significant public health risk as had been experienced elsewhere. While drugs such as meth may not be as problematic at a population level compared with other drugs (despite media concerns, etc), it is important that providers are made aware of any trends/changes in drug use patterns before they became problematic.
- The impact of drug use on general health is also a concern. In commissioning support for work in this area, it will be important to highlight the public health and well-being importance. Social consequences of recreational drug use, including

cost of days of work off due to illness (and being exhausted after a weekend of partying) and that of violence and health and safety, should also be considered.

- When developing interventions, health promotion services should work closely with bars and clubs. One example cited was providing awards for good practice. Further, campaigns also need to consider the impact of use of recreational drugs in the home.
- The acceptability and effectiveness of generic drug treatment services versus LGBT-focused services should be evaluated.
- Health promoters should be realistic about the motivations of the media in their reporting of drug use and appeal to business model (ie, the need to sell papers) rather than an altruistic model when working with the media.
- Health promotion messages should be more visible and age-specific.
- Approaches to health promotion need to be considered within the current context of spending cuts in term of training, reconfiguring care pathways, developing unmet capacity, and considering existing services.
- Consider using social marketing approaches to health promotion that focus on issues that are important to MSM.

Are there critical gaps in what we know and what we currently do and if so what could plug into these gaps?

- There is little evidence from the UK on health promotion interventions that address substance use among MSM, although evaluations have been done elsewhere.
- This wider evidence should be reviewed in order to inform the development of interventions appropriate to the UK. These can then be evaluated within the UK context.

- In order to better train generic service providers, we will need further evidence of men's experiences of accessing services, particularly generic services. Guidelines could then be developed for making these services more accessible and acceptable to LGBT. Evidence is needed on how existing tools and guidance are delivered. Proper implementation of guidance tends not to be a focus unless it is properly assessed.
- Efforts should be made to put this on the inequality/equality agenda. Arguing for the cost-effectiveness of providing equal services should also be considered.
- How are prevention, harm reduction and problematic drug use amongst MSM being addressed?
- Should more targeted work be considered or should generic work be made to accommodate different groups?
- Enough is known about the local demographic to be able to commission services. It just needs to be evidenced. How do we translate statistics from generic drug treatment services into evidence? Can researchers suggest methods of collecting and using data from services to take to commissioners?
- Further research is needed to explore risk taking in particular contexts, for example sex parties.
- In general there is a lack of knowledge about this issue from outside London. Regional data need to be tied into national policy.
- We need to learn more about what is going on in the home and the overall context of drug use.

What is the role of CHAPS as the national programme, its partners and the wider sector in taking forward and influencing the direction of work?

- CHAPS could have a role in informing the development of appropriate health promotion for MSM substance use as well as coordinating delivery of such interventions.
- The development of an 'Evidence Exchange' or an 'Evidence Depository' website including links to all information and data about drugs and alcohol for the sector. This may help instigate online dialogue.
- Preparing a taskforce that feeds into the work of the Association of Chief Police Officers and the Home Office.
- Continuing to hold discussions similar to this symposium.
- Conduct further analyses in GMSS looking at regional variations.
- Demonstrating best practice.

Conclusions and recommendations

There are few rigorous studies examining whether/how drugs are associated with sexual risk behaviour and none from the UK. Nonetheless, what existing evidence there is suggests that rather than there being one or two particular drugs that are uniquely associated with increased risk, it is more likely that most illicit drugs as well as alcohol are associated with increases in risk.

Although club drugs such as ketamine and 'new' drugs such as methamphetamine and methadone are gaining a lot of attention, from a public health perspective it is likely to be the more commonly used drugs, such as alcohol, cannabis and poppers which are most implicated in sexual risk and HIV transmission. Although methamphetamine use does appear to be increasing and is not restricted to London, relatively few men use the drug – probably around 5% overall and around 15% among certain groups – and most of these users report doing so relatively infrequently. Because of this even if use of methamphetamine during a sexual encounter substantially increases the likelihood of sexual risk in that encounter, it is still not likely to be implicated in very many episodes of sexual risk across the overall population of MSM.

Recommendation 1: Develop HIV health promotion for MSM that aims to reduce overall rates of substance use (particularly those substances most commonly used such as alcohol, cannabis and poppers) and to enable men to manage substance-related sexual risk.

There is a lack of evidence from the UK on health promotion interventions to address drug use and sexual risk,

although some studies have been done in the USA and elsewhere. Before proceeding to develop interventions in the UK and to subject these to rigorous evaluation, it would be sensible to conduct a review of the literature on existing intervention studies in order to inform the development of an intervention appropriate to MSM in the UK.

Recommendation 2: Undertake a systematic review of existing studies of substance-use prevention/harm minimisation interventions targeting MSM.

It is likely that a combination of whole-population and targeted interventions are needed in order both to reduce overall rates of substance use and also to enable men to minimize sexual health risks associated with substance use. Interventions might aim to improve men's health-related knowledge, self-esteem and skills in order that they make more informed, empowered decisions regarding their substance use. Health promotion might be delivered in the venues in which alcohol and other substances are consumed or via websites that men use to meet sexual partners. Decisions about appropriate settings could be informed by evidence about the contexts in which substance use is associated with sex and sexual risk, such as sex venues, internet-facilitated sex parties or sex after attending a gay bar or club.

Interventions might also address the wider determinants of substance use and related harms. These might include working to address the social pressures on men to drink and use substances, and to change gay commercial venues for example by providing more seating to move away from 'vertical drinking', reducing loud music, and training staff not to serve drunk men. Licensing

regulations can be used to enforce such changes and this has been successful done in bars in Australia.

Recommendation 3: Informed by the above review as well as existing practice, pilot health promotion interventions addressing substance use among MSM, including both individually-focused and structural interventions as appropriate.

Preventing other non-sexual drug-related harm for MSM is important. Health promotion could address issues such as overdosing, the mental and physical effects of long-term drug use etc. Whether addressing these health topics is important for HIV health promoters needs careful consideration.

In terms of drug treatment services, the presentations above suggest there is a need to examine what services are currently available that either specifically aim to cater for MSM or which are generic but nonetheless aim to address the range of drugs most commonly used by MSM (rather than focusing predominantly on crack and heroin). A better sense is needed of what factors act as barriers to MSM using drug treatment services and what combination of generic and targeted services would best serve MSM's needs. Whether the priority is for LGBT-specific provision or for ensuring that mainstream services cater for MSM and other recreational drug users may vary geographically, the former being more feasible in cities such as London with particular large numbers of LGBT people engaged in substance use.

In making the case for more appropriate drug treatment services it might be useful to make common cause with other agencies pressing for improved drug treatment for recreational drugs (ie, other than crack or heroin). A barrier to

change is the current policy focus on the crime consequences of heroin/crack use and this informing how 'problematic' is defined. There may be a need for advocacy at the central, strategic level.

*Report compiled by Annik Sorhaindo,
London School of Hygiene and Tropical
Medicine.*

In arguing for improved drug treatment services for MSM, it may be useful to make a case for the importance of this for HIV prevention and allow 'problematic' to include the problematic public health consequences of substance use. However it would be unwise to overstate this. This is because a relatively small proportion of sexual risk taking will involve substance use that participants regard as problematic. More sexual risk taking is likely to be associated with the use of substances such as alcohol, cannabis and poppers that users generally do not regard as problematic and are therefore unlikely to seek treatment for. Although some of the drugs such as methamphetamine which causes most immediate harm to physical and mental health may themselves be associated with increased sexual risk because fewer MSM use them and use them less frequently so they are likely to make a much smaller contribution to overall HIV incidence than other, less obviously harmful substances. While arguments for improved drug treatment services can refer to HIV prevention, it is also important they refer to other problems relating to physical and mental health, economic costs of absenteeism, etc. In taking this forward, we should first determine which levers can be used at both the national and regional levels to raise the profile on this issue.

Recommendation 4: Explore options for collaborative work with other agencies and sectors to lobby policy-makers for more appropriate and acceptable drug treatment services for MSM addressing recreational use, whether this be LGBT-specific services or generic.

The HIV and sexual health charity for life

Registered address: 314-320 Gray's Inn Road, London WC1X 8DP

Website: www.tht.org.uk **Tel:** 020 7812 1600 **Email:** info@tht.org.uk **THT Direct:** 0845 12 21 200

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