TWIST Training With Stakeholders
Applying EU Addiction Research

Sexuality, chemsex and club drugs
What are the priorities?

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About me

- Consultant Psychiatrist – addiction specialist
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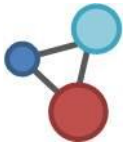
- Chair, Advisory Council on the Misuse of Drugs



About you

What we will talk about today

- How do sexual activity and psychoactive drug use **interact** to cause harm?
- Are problems related to co-occurring drug use and sexual activity a cause for **concern**?
- How are services currently **configured** across Europe for people with these problems?
- What could an **improved** service look like?
- What **steps** need to be taken to improve the care of people with harms related to co-occurring drug use and sexual activity?

What we won't talk about

- Alcohol
- General population screening and prevention for drug use or sexual activities

- Instead focus will be on **treatment interventions**

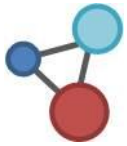
Two concepts of harm

Drug related harm

- Psychoactive drugs can be consumed without apparent harm
- However harms can be physical, psychiatric and social
- WHO category (ICD-10)
  - **harmful, dependent**

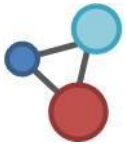
Sexual activity related harm

- Sexual activity typically results in no harm
- However harms can be direct or indirect
- E.g. acquiring and onward transmission of infectious disease, physical or psychiatric distress as result of sexual activity



How do sexual activity and psychoactive drug use **interact** to cause harm?

- Complex area
- For most people, combination of drug use and sexual activity results in no harm
- However for some, interaction leads to drug or sexual related harm or both
- **Four models** describe different interactions



Model 1

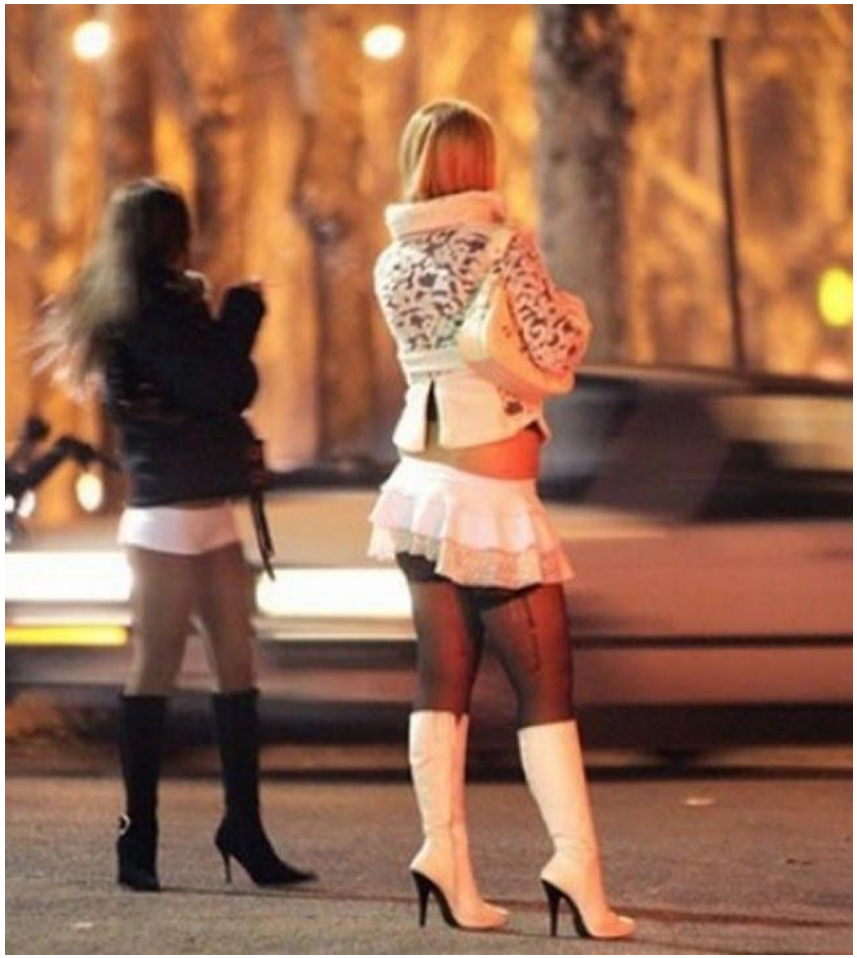
- Drug use leads to intoxication and disinhibition
- While intoxicated, individual engages in ***unintended*** sexual activities which **may or may not be consensual** but which are regretted
- Sexual activity was ***not the intention*** when the drug was consumed but took place as a result of intoxication
- Sexual activity (or a part of it, e.g. non-condom use) would be ***unlikely*** to have occurred if drug not consumed

- **Example:** Poly-drug intoxication leading to sexual assault

- **Particular risks:** Sexual assault, pregnancy, STI

Model 2

- People with established **harmful or dependent drug use** engage in sexual activities that either directly or indirectly put their sexual health at risk
- **Example:** To **fund drug use**, people are **drawn into the sex industry**
- **Particular risks:** STIs including those caused by blood-borne viruses (BBVs), drug overdose, sexual assault

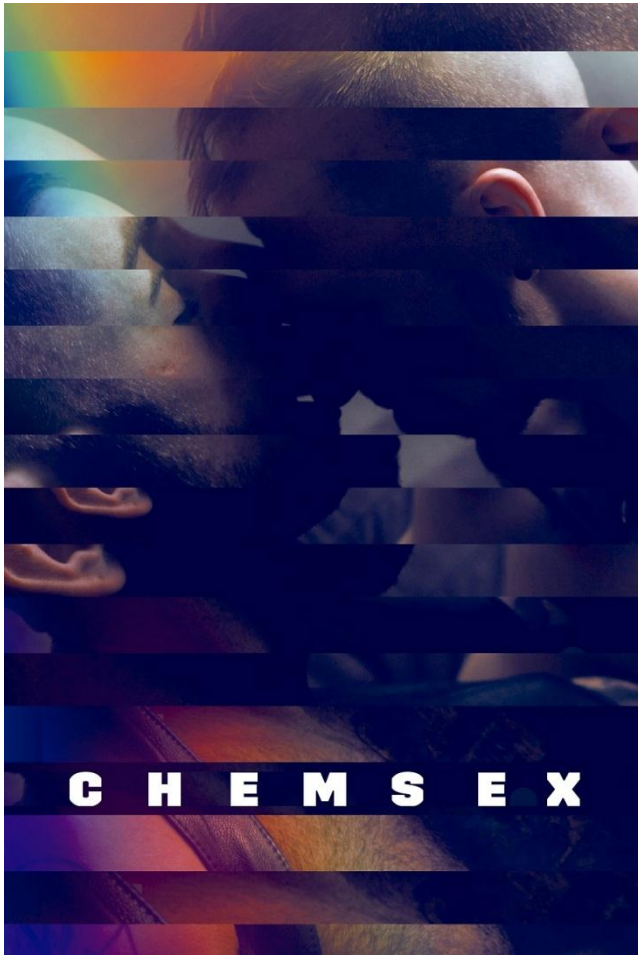


Model 3

- Drug use immediately before or during sex with the ***specific intention of enhancing sexual performance and pleasure***. Sexual activity is directly and deliberately ***facilitated*** by drug use.

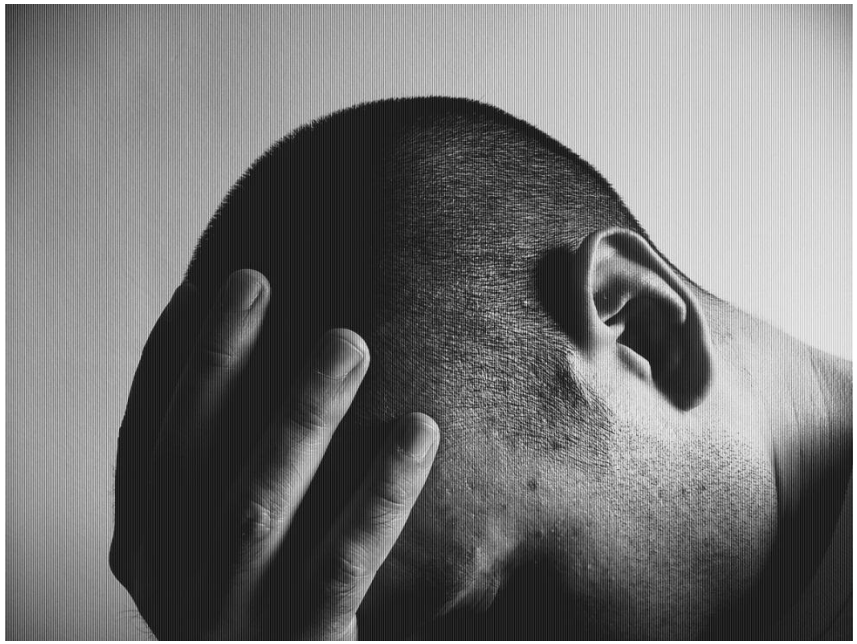
- **Example:** Methamphetamine, GHB, mephedrone in the context of sex parties ('chemsex').

- **Particular risks:** High-risk sexual activity, STIs, sexual assault, harmful or dependent drug use, drug overdose.



Model 4

- Drugs are used to **cope with the emotional distress** associated with a sexual-related health problem (new diagnosis, ongoing debilitating symptoms or associated stigma)
- **Example:** Newly diagnosed HIV infection, leading to harmful substance use to cope
- **Particular risks:** Harmful/dependent drug use, mental health probs such as depression or post-traumatic stress disorder.

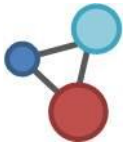


Exercise 1

Discuss these four models

Can you think of examples from your own work?

Can you think of any interactions which are not described by the four models?



What does research tell us about the size of the problem?

Harmful psychoactive drug use

- **One in four** adults in Europe have used an illicit drug in lifetime
- Harmful practices **vary greatly** between countries
- HIV infections attributed to drug injection falling. **4%** of all HIV infections
- HIV positivity among injecting drug users around **5%** in Europe with wide variation between countries.
- Little known about role of **non-injecting drug use** and high-risk sexual activities – but some groups more vulnerable e.g. **LGBT, particularly MSM**

Harmful sexual activity

- Complex research area
- Prevalence of STI **varies widely** across Europe
- Most common infection in Europe - **chlamydia**
- Some groups more vulnerable –e.g. **young people, MSM**
- Harms not just **short term** e.g infection but also **long term**
- e.g PID, infertility

What is the overlap of harm between drug use and sexual activity?

- Poor data. Difficult to link harms due to different data reporting structures
- UK GUM-CAD study asked GUM attendees
- *'Were you under the influence of recreational drugs (before or during sex) with any partner in the last 3 months?'*
- 9,000 respondents.
- Overall **6.6%**; Hetero **4.1%**; MSM **12.1%**
- Little data from drug services. One study of drug treatment seeking MSM reported **73% 'sexualised drug use'**
- **Does not address causation**

Exercise 2

Think about the services in your area.

How do drug services and sexual health services collaborate?

Can you think of advantages and/or disadvantages of your local service configuration?

Keeping sexual health and drug services separate

Advantages

- Patient **clearly identifies** service they wish to attend
- Unlikely to be asked **unexpected/**potentially **intrusive** questions
- Separate services allows **expertise/funding** to be focused where they are needed

Disadvantages

- Staff lack expertise to **identify** co-occurring problems. Missed opportunity
- Full **disclosure** less likely – perceived stigma?
- Services **difficult to navigate** for vulnerable population
- Lack of shared expertise

What is the current service offer?

Drug services

- Advice on safer drug use practices
- Needle exchange
- Provision of condoms
- Assessment and management of harms related to **drug use**, (opioid substitution treatment, medically assisted detox, relapse prevention)
- Motivational enhancement approaches
- Signposting to other services

Sexual health services

- Advice on safe sexual practices
- Provision of condoms
- Contraception advice and provision
- Assessment and management of a range of harms related to **sexual activity**, including screening and treatment of STIs
- Motivational enhancement approaches
- Signposting to other services

Exercise 3

- **<u>Improving the service offer</u>**

- **For drug treatment/sexual health services**
  - How should such patients be **identified** ?
  - What level of **assessment** is appropriate ?
  - Which **interventions** should be provided ?

Drug treatment services

-improving the offer

- **Advice to prevent/reduce harm related sexual activity**
  - should **provide info** on reducing harm from sexual activity
- **Sexual health assessment**
  - be able to **sensitively enquire** about sexual health, **identify** high-risk/harmful behaviours & offer **advice** to reduce harm
- **Sexual health interventions**
  - Once problem identified, drug treat services should offer:
    - **basic harm reduction advice** regarding high-risk sexual behaviours
    - **brief intervention** regarding high-risk sexual behaviours
    - **rapid pregnancy testing**
    - **rapid HIV and hepatitis testing**
    - **onward referral** to sexual health services where appropriate

Sexual health services
- improving the offer

- **Advice on preventing or reducing drug-related harm**
  - should provide **information on harms** related to drug use and ways to reduce such harms
- **Drug use assessment**
  - should be competent to **sensitively enquire** about substance use, **identify** patterns of problematic use and offer **advice** on ways to reduce harm
- **Drug misuse intervention**
  - Once a problem related to drug use has been identified, sexual health services should offer:
    - **basic advice** to reduce drug-related harms
    - **brief interventions** for drug-using behaviours
    - **onward referral** to drug services where appropriate

Next steps

- **Understanding the extent of the problem**
  - Develop **mandatory data collection tools** for both services to improve identification of co-occurring drug use and sexual activity
  - **Encourage research** to better understand the profile of the group and its risk behaviours and treatment needs.
  - **Economic analysis** of the benefits of closer working between sexual health and drug treatment services

Next steps II

- **Sharing expertise, developing treatment pathways**
  - Develop training for **sexual health staff** covering basic identification, assessment and brief intervention for **drug misuse problems**
  - Develop training for **drug treatment staff** covering basic identification, assessment and brief intervention for problems related to **sexual activity**
  - Encourage **closer working** between two services e.g. jt educational events at local, national, pan-European level
  - Review treatment pathways for **other** co-occurring problems e.g. drug misuse and mental health problems

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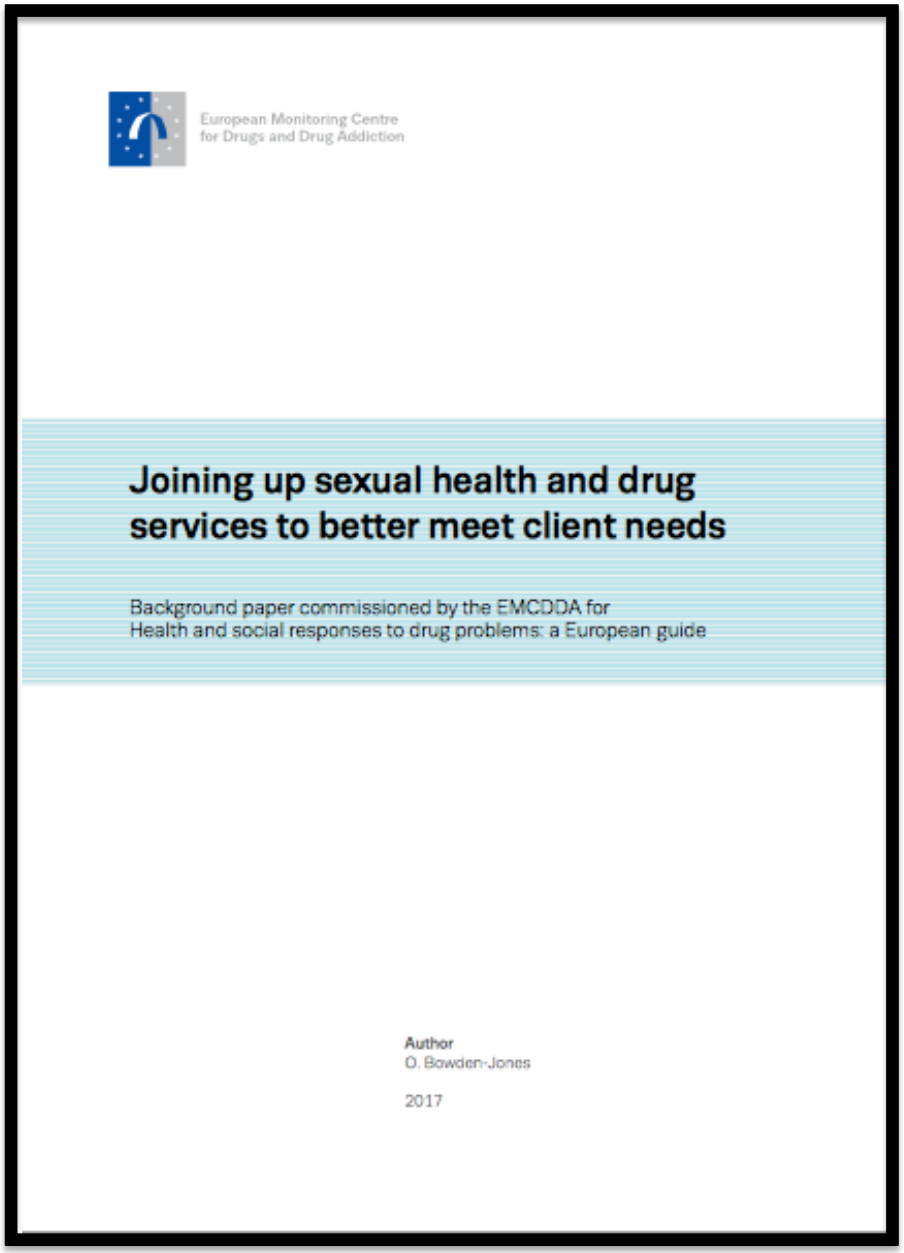

Thank you!

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