



European Monitoring Centre
for Drugs and Drug Addiction

Joining up sexual health and drug services to better meet client needs

Background paper commissioned by the EMCDDA for
Health and social responses to drug problems: a European guide

Author

O. Bowden-Jones

2017

Joining up sexual health and drug services to better meet client needs

Dr Owen Bowden-Jones FRCPsych MSc (Imperial) MBChB

Consultant Psychiatrist and Lead Clinician for Club Drug Clinic, Addictions Directorate, Central North West London NHS Foundation Trust; Honorary Senior Lecturer, Imperial College, London; Chair, Advisory Council on the Misuse of Drugs; and Clinical Adviser, Alcohol, Drugs and Tobacco Division, Public Health England

October 2017

This paper was commissioned by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) to provide background information to inform and contribute to the drafting of *Health and social responses to drug problems: a European guide*.

This background paper was produced under contract CT.16.SDI.0139.1.0 and we are grateful for the valuable contribution of the author. The paper has been cited within *Health and social responses to drug problems* and is also being made available online for those who would like further information on the topic. However, the views, interpretations and conclusions set out in this publication are those of the author and are not necessarily those of the EMCDDA or its partners, any EU Member State or any agency or institution of the European Union.

1. Introduction

The aim of this paper is to focus on the harmful interaction between psychoactive drug use and sexual activity. It is acknowledged that in some individuals co-occurrence of drug consumption and sexual activity causes no apparent harm, but this group will not be considered here.

To understand the harmful interaction between drug consumption and sexual activity, and to consider its implications for treatment needs, this briefing paper will address the following questions:

- How do sexual activity and psychoactive drug use interact to cause harm?
- Are problems relating to co-occurring drug use and sexual activity a cause for concern?
- How are services currently configured across Europe for those with problems relating to co-occurring drug use and sexual activity?
- What could an improved service look like?
- Are there examples of innovative responses to co-occurring problematic drug use and sexual activity from across Europe?
- What steps need to be taken to improve the care of people with problems relating to co-occurring drug use and sexual activity?

This briefing paper will focus largely on treatment interventions and will not specifically address issues such as general population screening and prevention. There is not scope to consider the role of alcohol, although there is a sizeable literature examining the interaction between alcohol and sexual activity. Alcohol and drugs are often consumed together, however, and the risks typically increase when more than one psychoactive substance is used simultaneously.

Two concepts of harm will be used throughout.

Harm related to drug use

Psychoactive drugs can be consumed without apparent harm, and this is often termed 'recreational' drug use. When drug use causes harm, whether physical, psychological or social, it is often termed 'drug misuse'. The severity of harm is categorised using World Health Organization (WHO) criteria and defined as 'harmful' or 'dependent' (WHO, 1992).

Harm related to sexual activity

Sexual activity typically results in no apparent harm. There are, however, examples of harm that are directly or indirectly related to sexual activity. Examples include the acquiring and onward transmission of infection diseases such as gonorrhoea, and sexual activity that results in physical trauma or psychological distress.

2. How do sexual activities and psychoactive drug use interact to cause harm?

The interaction between sexual activity and drug use can be complex, but in most people results in no apparent harm. In some people, however, the interaction leads to drug- or sexual-related harms, or both. Broadly speaking, there are four models that describe these harmful interactions.

Model 1

Drug use leads to intoxication and disinhibition. While in a state of intoxication, the individual engages in unintended sexual activities that may or may not be consensual but which are regretted once the intoxicating effect has worn off. Crucially, the sexual activity was not the intention when the drug was consumed, but took place as a result of drug intoxication. Sexual activity (or a specific aspect of it, such as no condom use) would be unlikely to have occurred unless the drug was consumed.

Example: cocaine intoxication leading to sexual assault.

Particular risks: pregnancy, sexually transmitted infections (STIs), sexual assault.

Model 2

People with established harmful or dependent drug misuse problems engage in activities that either directly or indirectly put their sexual health at risk.

Example: To fund drug use, people are drawn into the sex industry, leading to an increased risk of STIs and sexual assault.

Particular risks: STIs including those caused by blood-borne viruses (BBVs), drug overdose, sexual assault.

Model 3

Psychoactive drugs are used 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: The consumption of methamphetamine, gamma-hydroxybutyrate (GHB)/gamma-butyrolactone (GBL) and 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 such as a new diagnosis, ongoing debilitating symptoms or associated stigma.

Example: Newly diagnosed human immunodeficiency virus (HIV) infection, leading to harmful substance use to cope with this diagnosis.

Particular risks: Harmful or dependent drug use, mental health problems such as depression or post-traumatic stress disorder.

3. Is the co-occurrence of drug use and sexual activity causing significant problems in Europe?

As the above examples suggest, the interaction between drug use and sexual activity can be complex and cause harm, but how common is this harm?

Psychoactive drug use

Drug use is common, with one in four Europeans estimated to have used an illicit drug in their lifetime (EMCDDA, 2016a). Harmful practices vary considerably between countries; for example, the prevalence of injecting use ranges from less than one up to nine per 1 000 population aged 15 to 64 across Europe. Heroin is still the most commonly injected substance, although the prevalence of heroin injection has been steadily falling over the last decade in most of Europe. There is, however, increasing concern about the injection of amphetamine and novel psychoactive substances.

HIV infections attributed to drug injecting have also been falling and are now estimated to represent around 4 % of all HIV infections. This figure does not include HIV infection attributable to the co-occurrence of non-injecting use and high-risk sexual activities, the incidence of which is unknown. The prevalence of HIV positivity among injecting drug users is estimated to be around 5 % in Europe as a whole, with significant variation between countries.

Rates of hepatitis C virus (HCV) infection among European injecting drug users vary between 15 % and 84 %, and in most countries are above 50 %. Worryingly, it is thought that many of those affected are unaware that they are infected; estimates of the proportion of HCV-positive individuals who fall into this category vary from 24 % to 76 %.

Increased risk of problematic drug use is associated with mental health problems, men who have sex with men (MSM), young people, socioeconomic deprivation, chronic pain and a genetic vulnerability to substance misuse.

Sexual activity

The epidemiology of harms related to sexual activity across Europe is difficult to interpret due to heterogeneity of reporting and differences between healthcare systems.

Based on available data, rates of STIs vary widely across Europe and, like drug use, are highest among young people and MSM (ECDDA, 2016b).

Morbidity associated with STIs is related not only to acute infection but also to longer-term harms such as pelvic inflammatory disease and infertility. The most commonly notified STI in Europe' is chlamydia, with a prevalence of 182 cases per 100 000 population, although the true prevalence may be higher because many affected individuals are asymptomatic.

What is the overlap between harms related to drug use and sexual activity?

Current data-reporting structures across Europe make it difficult to link harms related to sexual activity and those attributable to drug use, as services provided to address these two problems rarely share data collection methods. This makes it hard to accurately identify and characterise people with co-occurring problems attending both services. There is a need to better understand the size of this population, and its profile and treatment needs.

In the United Kingdom, the genitourinary medicine clinical activity dataset (GUMCAD) gathers information on attendees at sexual health clinics, who are routinely asked 'Were you under the influence of recreational drugs (before or during sex) with any partner in the last 3 months?'. Data from nearly 9 000 respondents suggest that the prevalence of drug-influenced sexual activity is 6.6 %. The rate is lower among heterosexual women (4.1 %) and higher among MSM (12.1 %) (Mohammed et al., 2016).

Drug services do not routinely collect information on sexual activity. Small studies suggest that rates of sexualised drug use may be as high as 73 %, but this figure varies widely depending on the treatment population (Bowden-Jones et al., 2017).

However, studies that have examined both treatment populations do not describe any causation between sexual activity, drug use and harm. There are relatively few data to inform the prevalence of harm in people outside treatment settings (Bourne et al., 2015; Schmidt et al., 2016).

Despite the challenges of limited data, there is an apparent overlap between the two treatment services populations. Young people, MSM and people working within the sex industry appear to be at the highest risk of co-occurring harms relating to drug use and sexual activity.

4. How are services currently configured across Europe for those with co-occurring harms relating to drug use and sexual activity?

Across Europe, treatment services for drug and sexual health problems are typically funded separately, and services often have different eligibility criteria and catchment areas. For example, many sexual health services can be accessed anonymously without an appointment, irrespective of home address. Many drug treatment services also offer a 'no appointment' approach, but in some countries access is determined by area of residence. This can result in people who travel to a preferred sexual health service being eligible for treatment of their sexual health problems but ineligible for care at the nearest drug treatment service, as

they are outside the relevant catchment area. Sexual health and drug treatment services in Europe are rarely co-located. This may be particularly challenging for groups with complex needs for whom 'joined-up' care would be particularly indicated (e.g. people working in the sex trade, homeless populations and those receiving treatment for HIV infection).

There are, however, some advantages to offering specialist sexual health and drug treatment services separately. Patients can clearly identify the service they wish to attend and will usually have a good idea of what to expect. They are unlikely to be surprised by questions about other areas of their lives, which they may experience as intrusive. Separate services also allow expertise and funding to be focused where they are needed.

The drawbacks of separate services include:

- Staff lack the expertise to correctly identify and assess co-occurring problems, which can result in a missed opportunity to intervene. For example, a patient attending drug treatment services to receive support for cocaine misuse may not be asked about patterns of sexual activity or STIs when, in fact, the use of cocaine to facilitate paid sexual activity has led to repeated STIs. An opportunity has been missed not only to treat the infections but also to fully understand the motivations behind the drug use and possible solutions.
- People attending one service may feel unable to disclose the full complexity of their issues due to concerns about stigma or lack of knowledge among staff.
- A lack of coordination of care between sexual health and drug treatment services can cause difficulties for the patient in navigating complex care pathways. Some patients, particularly those with severe drug misuse problems, will be particularly vulnerable, live chaotic lifestyles and be poorly motivated to access care. The lack of centralised care may necessitate travelling to different venues for help with different parts of the same complex problem. The barriers of travelling time, perceived stigma and inconvenience, and the challenge of finding the right help, may result in patients with complex needs failing to receive appropriate treatment.
- Some attendees of sexual health services believe that drug treatment services are 'just for heroin users' and that they lack sufficient expertise regarding the drugs more commonly used by attendees at sexual health services. Indeed, it may well be the case that mainstream drug services have limited experience of some types of drugs and patterns of use, for example the drugs used in 'chemsex', such as GHB/GBL. As a result, some groups of drug users, for example MSM who engage in 'chemsex', are frequently uncertain if drug treatment services can help them.

- There is a lack of sharing of expertise between sexual health and drug treatment services. Both staff groups receive structured training in their specialist area but gain little expertise in managing the complexity of a patient with co-occurring problems related to drug misuse and sexual activity.

5. What could an improved service look like?

Improving the treatment offered to those with co-occurring harms related to drug use and sexual activity can be discussed by considering:

- how such patients are identified;
- what level of assessment is appropriate;
- which interventions should be provided.

The starting point for this discussion is a clear understanding of what each service currently offers and whether or not this needs to be enhanced. Table 1. shows the interventions offered at present by most services across Europe.

Table 1: Interventions typically offered by sexual health and drug treatment services in Europe

Sexual health services	Drug treatment services
Advice on safe sexual practices	Advice on safer drug use practices
Provision of condoms	Needle exchange
Contraception advice and provision	Provision of condoms
Assessment and management of a range of harms related to sexual activity, including screening and treatment of STIs	Assessment and management of a range of harms related to drug use, including opioid substitution treatment, medically assisted detoxification and relapse prevention
Motivational enhancement approaches	Motivational enhancement approaches
Signposting to other services	Signposting to other services

Interestingly, for both services, a key approach to reducing harm is helping the patient modify higher risk behaviours. Although each service focuses on different behaviours, this shared expertise in behavioural change is a clear opportunity for services to work together using a common therapeutic approach.

What should services be offering to patients with co-occurring harms related to drug use and sexual activity?

What could each service routinely add that would improve the care of people with harms related to co-occurring drug use and sexual activity? The first step is

the detection of a co-existing problem. The provision of advice on avoiding or reducing harm should be considered for all people attending services. This could be as simple as displaying posters or leaflets with harm reduction advice. At assessment, services should be able to enquire about drug use and sexual activity, and where this co-occurs further explore possible interactions and their impact.

Once a co-occurring problem has been identified, the next step is to define which interventions would be appropriate to each setting. It would be unrealistic to expect drug treatment services to undertake a detailed sexual health assessment and investigations. Likewise, sexual health services cannot be expected to complete a detailed assessment of drug harm. Instead, what could be reasonably expected of each service?

The following section outlines what sexual health and drug treatment services could offer in terms of advice, assessment and intervention.

Sexual health services

Advice on preventing or reducing drug-related harm

- Sexual health services should provide information to all patients on harms related to drug use and ways to reduce such harms.

Drug use assessment

- All sexual health services 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 be able to offer:
 - basic advice to reduce drug-related harms;
 - brief interventions for drug-using behaviours;
 - onward referral to drug services where appropriate.

Drug treatment services

Advice on preventing or reducing harm related to sexual activity

- Drug treatment services should provide information to all patients on ways to reduce harm from sexual activity.

Sexual health assessment

- All substance misuse services should be able to sensitively enquire about sexual health, to identify high-risk and harmful behaviours and to offer advice on how to reduce harm.

Sexual health interventions

- Once a problem related to sexual activity has been identified, drug treatment services should be able to 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.

6. Are there examples of innovative responses to co-occurring sexual activity and drug use problems across Europe?

There have been a number of responses from different European countries to problems related to co-occurring sexual activity and drug use. Some of these responses focus on defining and monitoring the problem, others on delivering services tailored to identify needs (EMDDA, 2016c).

Defining the problem:

Addictovigilance network, France (1)

The Addictovigilance network in France has used anonymous questionnaires, helplines and case reporting to build a picture of the developing 'chemsex' scene among MSM across France. This has helped in developing an assessment of need and informed the national policy response.

Improving access

Checkpoint (2) — Portugal, Spain, Italy, Greece, Denmark, Netherlands

Checkpoint is a generic term used to describe a range of community-run HIV and STI testing centres, which provide rapid testing to identified at-risk populations, for example MSM. These services often lie outside mainstream health systems. In some countries, for example Portugal, checkpoints have collaborated to form networks with common procedures, training and data collection. The focus has

(1) <http://www.addictovigilance.fr>

(2) <http://www.lisbongaycircuit.com/checkpoint-lx/>

been on rapid testing for HIV infection, syphilis and hepatitis B and C. Many checkpoints offer other services, such as more formal harm reduction approaches.

Providing information and improving knowledge

QUADROS (quality development in counselling and prevention in the context of drugs and sexuality in gay men), Germany ⁽³⁾

Established by Deutsche Aidshilfe (DAH) in cooperation with seven partner organisations in Berlin, Frankfurt, Nuremberg and Munich, the partnership aims to increase knowledge of legal and illegal drugs among MSM, to strengthen counselling and referral competencies in gay counselling, prevention projects, and AIDS and low-threshold drug counselling sites, and to identify gaps in service provision.

Delivering care

Chelsea and Westminster National Health Service (NHS) Foundation Trust and Central North West London NHS Foundation Trust, United Kingdom ⁽⁴⁾

Sexual health and drug treatment providers in one area of London have collaborated to provide a team comprising a psychiatrist, a substance misuse practitioner and a sexual health practitioner offering appointment-based assessment and treatment of problems related to co-occurring drug use and sexual activity. If more intensive drug treatment is needed, the team signposts clients to the relevant local service.

7. What are the next steps that could be taken to improve the care of people with problems related to co-occurring sexual activity and drug use?

There remains uncertainty regarding the prevalence of problems relating to co-occurring drug use and sexual activity across Europe, both in populations accessing treatment and in those who have not sought help. Despite these uncertainties, there is increasing evidence of harm, particularly among MSM. Many drug treatment and sexual health services acknowledge they do not have the knowledge to tackle co-occurring problems, that expertise is not widely shared and that treatment pathways are not typically designed to best meet the needs of this group.

As yet the evidence base has not clearly identified a better model than the current separation of services, although new approaches are beginning to emerge. In the absence of a clearer evidence base, it would seem sensible to develop services incrementally, rather than suggesting radical and expensive redesign. Some relatively simple first steps could improve the overall treatment on offer to those with problems relating to co-occurring drug use and sexual activity, as follows.

⁽³⁾ <https://www.aidshilfe.de/shop/quadros>

⁽⁴⁾ <http://clubdrugclinic.cnwl.nhs.uk/ghb-trial/>
<http://www.chelwest.nhs.uk/services/hiv-sexual-health/clinics/john-hunter-clinic-for-sexual-health>

Understanding the extent of the problem

- Develop mandatory data collection tools for sexual health and drug treatment services to improve the identification of people with problems relating to co-occurring drug use and sexual activity.
- Encourage research into problems experienced by those who participate in co-occurring drug use and sexual activity to better understand the profile of the group, their risk behaviours and treatment needs. Furthermore, an economic analysis of the benefits of closer working between sexual health and drug treatment services is indicated.

Sharing expertise, developing treatment pathways

- Design and implement training for sexual health staff covering basic identification, assessment and brief intervention for drug misuse problems.
- Design and implement training for drug treatment staff covering basic identification, assessment and brief intervention for problems related to sexual activity.
- Encourage closer working between the two services through joint educational events at local, national and pan-European level.
- Review treatment pathways adopted for other co-occurring problems, for example drug misuse and mental health problems, to learn the lessons of what works and what does not.

To conclude, improving data collection and encouraging research is essential if the extent of problems related to co-occurring drug use and sexual activity is to be better understood. Encouragingly, the expertise needed to identify, advise and treat those with such problems is already available within sexual health and drug treatment services. The challenge is to share expertise and develop appropriate treatment pathways for the benefit of this vulnerable group of people.

References

Bourne, A., Reid, D., Hickson, F., Torres-Rueda, S., Steinberg, P. and Weatherburn, P. (2015), '“Chemsex” and harm reduction need among gay men in South London', *International Journal of Drug Policy* 26, pp. 1171-1176.

Bowden-Jones, O., Whitelock, C., Abdularahim, D., Hemmings, S., Margetts, A. and Crawford, M. (2017), 'Prevalence of HIV-risk related drug use and sexual activity among men who have sex with men attending a specialist UK club drug clinic', *Drugs and Alcohol Today* 17, pp. 50-59.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2016a), *European drug report 2016: trends and developments*, Publications Office of the European Union, Luxembourg.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2016b), *Drug-related infectious diseases in Europe: update from the EMCDDA expert network*, Publications Office of the European Union, Luxembourg.

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) (2016c), *Health responses to new psychoactive substances*, Publications Office of the European Union, Luxembourg.

Mohammed, H., Were, J., King, C., Furegato, M., Nardone, A. and Hughes, A. (2016), 'Sexualised drug use in people attending sexual health clinics in England', *Sexually Transmitted Infections* 92. p/ 454.

Schmidt, A. J., Bourne, A., Weatherburn, P., Reid, D., Marcus, U. and Hickson, F. (2016), 'Illicit drug use among gay and bisexual men in 44 cities: findings from the European MSM Internet Survey (EMIS)', *International Journal of Drug Policy* 38, pp. 4-12.

WHO (World Health Organization) (1992), *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*, WHO, Geneva.