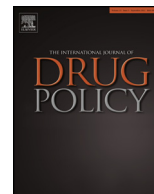




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Demand for and availability of specialist chemsex services in the UK: A cross-sectional survey of sexual health clinics

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ABSTRACT

Background/introduction: Chemsex amongst men who have sex with men (MSM) is well documented in major cities within the United Kingdom (UK), but few data from less urban areas exist. We undertook a survey of sexual health clinic (SHC) healthcare workers (HCWs) to explore demand for and availability of chemsex services to understand training needs and inform service planning.

Methods: An online survey was distributed to HCWs in all SHCs across the UK. For English clinics, we explored associations between responses and geo-demographic region using national surveillance data and population statistics.

Results: Responses were received from 56% (150/270) of SHC's in the UK (89% (133/150) from English clinics). 80% (103/129) of UK clinics reported chemsex consultations and in 50% (65/129) these occurred at least monthly, with no significant difference found when analysed by the geo-demographic characteristics of England ($p=0.38$). Respondents from most clinics (99% (117/118)) wanted chemsex training, 81% (103/129) felt there was a local clinical need for a chemsex service and 33% (14/43) had chemsex care-pathways for referrals in place. **Discussion/conclusion:** Patients reporting chemsex regularly present to SHCs throughout the UK including rural areas. Given the potential negative health outcomes associated with chemsex, there is a need for local, high quality, appropriate services and training to minimise harm.

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Background

Chemsex has been defined as engaging in sexual activities while under the influence of specific recreational drugs (Crystal Methamphetamine, Mephedrone and γ -hydroxybutyrate (GHB) (McCall, 2015)) taken before or during sex. This typically occurs between men who have sex with men (MSM) and is associated with high-risk sexual practices (group sex and condomless anal intercourse (Daskalopoulou et al., 2014; Gilbert et al., 2015)) which in turn may result in increased transmission of sexually transmitted infections (STI's), enteric infections (notably Shigellosis Gilbert et al., 2015), Hepatitis C and HIV (Kall, Shahmanesh, Nardone, Gilson, & Delpech, 2014).

Multiple studies have demonstrated that MSM are more likely to have used recreational drugs than men who have sex exclusively with women (Daskalopoulou et al., 2014; Mercer, 2015; Mohammed et al., 2016). In the Astra Study (Daskalopoulou et al., 2014), half of the HIV-positive MSM studied reported recreational drug use in the previous three months. Among these, nearly 20% reported condomless sex with partners of unknown HIV status and 32% reported group sex.

Targeted chemsex services have been developed in some Sexual Health Clinics (SHCs). 'The Chemsex Study' (Bourne et al., 2015) demonstrated, via qualitative interviews, that in general, MSM felt comfortable discussing chemsex within Sexual Health Clinics (SHCs).

There are limited data available from the United Kingdom (UK) on the prevalence and frequency of chemsex in MSM and most are from SHCs in London or other large conurbations, reflecting larger MSM populations in these areas. We undertook a survey of SHC

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healthcare workers (HCWs) to explore demand for and availability of chemsex services across the UK, including in less urban areas, to inform service planning.

Method

Survey development and implementation

An online survey, including questions on frequency of 'chemsex consultations' (patient reporting chemsex to medical staff during consultation), staff training, specialist services and clinic policies, was developed using 'Select Survey' (Select Survey Class, 2018) software, with input from collaborating HCWs with clinical interest in chemsex. The survey was piloted by two SHCs and the members of British Association for Sexual Health and HIV (BASHH) National Audit Group (NAG), with no significant changes requested (Appendix 1). The survey was in two parts: Part one covered clinic policy and Part two, clinical experiences and training. As a service development project, a review by the research ethics committee was not required. Sexualised Drug Use

The survey was distributed to all level three (Parmar, 2017) UK SHCs (complex service provision) via an email to clinical staff, facilitated by trainee and NAG representatives. Non-responding clinics were sent reminders after one week.

Recipients were asked to distribute the survey to clinical staff, including the most junior team members who screened patients for STIs. To limit bias due to those with an interest in chemsex responding disproportionately, only staff that worked on a specific day were invited to participate (except clinical leads who were asked to complete the survey regardless). Clinical leads were asked to complete Part one and all respondents were asked to complete Part two.

Data analysis

Results were analysed by clinic. Where there were multiple responses per clinic, one response was selected for analysis, as follows:

- Any clinic with at least one respondent reporting chemsex consultations.
- Among the chemsex consultation clinics, the following hierarchy was applied, based on decreasing size of the respondent group: (i) nurses, (ii) doctors, (iii) HA's and (iv) 'other'. The exception was for the analysis of Part 1 which was directed only at clinical leads.

For clinics in England, data were available from the national STI surveillance system (GUMCAD) (Savage, Mohammed, Leong, Duffell, & Hughes, 2014) and were used, along with data from the Office for National Statistics Rural-Urban Classification for Local Authority Districts in England (Office of National Statistics, 2011), to stratify clinics into four geo-demographic categories: (A) Urban conurbation, (B) urban with city/town, (C) urban with significant rural and (D) non-urban. Similar data were not available for clinics elsewhere in the UK.

For clinic based analysis, Fisher's exact test with Bonferroni correction was used to examine associations between responses given by HCWs and regional variations (i.e. rural/urban) of the participating clinics. STATA v.13.1 was used for analysis and p values less than 0.01 were considered statistically significant (chosen after Bonferroni correction to address the fact that the probability of obtaining a spurious result increases with more tests taken).

Not all respondents answered each question, leading to small variations in the denominators.

Results

UK, RESPONDENT BASED DATA (results from all respondents)

Survey responses were received from 348 individuals from 56% (150/270) of UK SHCs. The majority were from English clinics (90%, 313/348). One per cent (3/348) were from Scottish, one% (4/348) Northern Irish (NI) and three% (10/348) from Welsh clinics. This represents an overall clinic response rate of: 63% (135/214) for England, eight%(3/39) for Scotland, 80% (4/5) for NI and 83% for (10/12) Wales. For England, clinic contact details were available via GUMCAD. Similar information was not available for the rest of the UK and this may be reflected in the lower response rates.

Using data about currently open English SHCs, the response rates by geo-demographic regions can be estimated as: 51%(40/78) for group A, 53% (41/68) for B, 59%(16/27) for C and 47% (16/34) for group D.

Most respondents worked in the following roles: Nurses (41% 144/348), Doctors (24% 84/348) consultants, junior doctors (5% 16/348), associate specialists (7% 24/348), and HA's (15%, 52/348). There were a small number of respondents who worked in 'other' roles.

CLINIC POLICY (Clinical leads only)

With regards to clinic policy, data from 20% (55/270) of consultant clinical leads were available for analysis (one clinical lead response per clinic selected): 48 from England, one from Scotland, 4 from Wales and two from N.I. There were 44 responses (44/55, 80%) available for the majority of policy questions. However, due to the lower numbers, a geo-demographic analysis was not performed.

Eleven per cent (5/44) of clinical leads reported a policy of asking all patients about a history of chemsex, 68% (30/44) asked such questions of selected patients and for the remainder, chemsex was not routinely investigated during consultations.

Most clinical leads 69% (33/48) reported that clinic policy does not require documentation of chemsex history in new patients. Nineteen per cent, 19% (9/48) said that this information is required from selected patients and 13% (6/48) that chemsex was routinely asked about with all new patients. Where chemsex was reported, the documentation of associated harms (acute or chronic- physical, psychological, social or financial) was clinic policy in 10.4% (5/48) of clinics.

Where referral for ongoing management was required, 54% (23/43) reported patient self-referral, 33% (14/43) a formal referral process, and 14% (6/43) reported informal referral processes. With regards to referral follow-up, 83% (39/47) did not have a process in place, 13% (6/47) did and 4% (2/47) did not know.

Clinic-based analysis

Demand for chemsex services (Table 1)

Eighty per cent (103/129) of clinics reported ever seeing patients reporting chemsex and 50% (65/129) that such consultations occurred at least monthly. These figures did not vary greatly across the UK (Fishers, $p=0.64$). A demand for a local chemsex service was reported by 67% (87/129) of clinics.

Chemsex interventions (select all that apply)

The most commonly reported interventions used were simple advice (90%, 43/47), sign-posting to NHS substance misuse services (53%, 25/47), external needle exchanges (55%, 26/47), brief-

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