Exploring service experiences among gay and bisexual men seeking to reduce or abstain from chemsex

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Disclosure of Interest

We have no conflict of interest with the presented material in this presentation.

OVERVIEW

1. ACON's context
2. Background evidence on chemsex
3. Service experiences findings
4. Overview of ACON's substance support counselling program
5. Overview of the M3THOD peer service
6. Client scenario activity
7. Take home messages

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CONTEXT

- Mid 2010s media, policy and community attention on ‘chemsex’.
- NSW ‘Special Commission of Inquiry into the Drug Ice’, underscored importance of community and peer-led programs and services (1).
- ACON’s long history of community-based and peer-led work spanning drug and alcohol and sexual health.
- Research funding.

1. Howard D, 2020

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BACKGROUND

Chemsex, sometimes referred to as ‘party and play’, ‘PnP’ or ‘sexualised drug use’ comprises the use of substances to facilitate sex characterised as expansive in terms of duration, partners, and activities. (2)

Multiple populations combine drugs with sex. 60% of clients accessing ACON’s counselling service are GBMSM reporting crystal methamphetamine as their primary drug of concern.

Convenience sampled surveys of GBMSM in NSW indicate that 8 percent report use of crystal methamphetamine and 11 percent report use of gamma hydroxybutyrate (GHB) within the past 6 months. (3)

It is estimated that about 85 percent of this use is for the purpose of enhancing sex. (4,5)

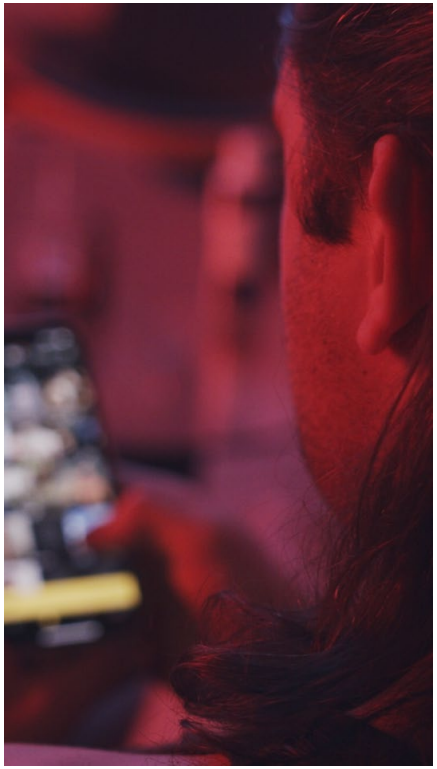

Image taken from ACON M3THOD campaign

2. Maxwell et al (2019)
3. Broady et al (2023)
4. Hammoud et al (2018)
5,. Hammoud et al (2018)

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CHARACTERISING THE EXPERIENCE

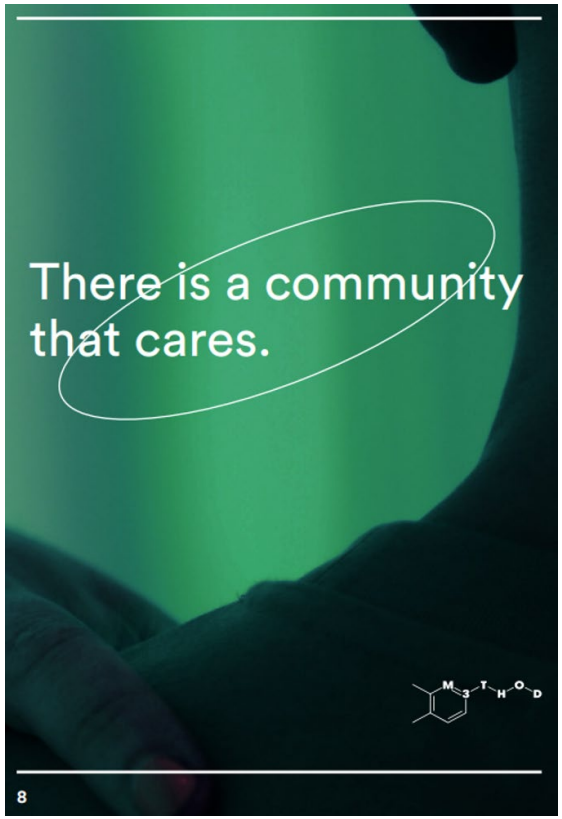

Image taken from ACON M3THOD harm reduction booklet

- Much research characterises chemsex as an experience of sex facilitated online, entailing adventurous sex, with multiple partners over a long duration, practices and behaviors that are inherently risky (6,7).
- Australian research reflects diverse practices of chemsex and highlights that this popular conception may alienate many (8).

6. Maxwell et al (2019)
7. Tomkins (2019)
8, Drysdale (2020)

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HARM REDUCTION PRACTICES

Settings	Gatekeeping	Temporality
Transmission risk	Communication	Community care

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HARM

Not all who practice chemsex experience harms but the literature explores and documents associations between chemsex and:

- HIV & STIs, (HIV risk mediated by PREP and ART) bacterial STIs, prevalent (9, 10).
- Hepatitis C (11, 12).
- Overdose, injury, acute mental health incidents and death (13,14, 15).
- Mental health conditions (16, 17).
- Sexual wellbeing (sexual violence, reliance on drugs for sex) (20).

9. Guerra FM, (2020) 10. Wood BR, (2022) 11. Pufall EL, (2018) 12. Hopwood M, (2014,) 13. Hockenhull J, (2017), 14. Korf DJ, (2014) 15. Moreno-Gamez (2022) 16. Bohn A, (2020), 17. Power J, (2018) 18. Hegazi A,(2017), 19. Closson EF, (2018). , 20. Bourne A, (2015)

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GHB OVERDOSE

GHB's steep dose response curve, variations in batch strength and purity, variations in tolerance and pronounced dangers associated with poly-drug use, GHB presents a high risk for overdose.

Between 2012 and 2018 there was a **147% increase** in the prevalence of GHB-related ambulance attendances in the Australian State of Victoria (n=5,866 attendances in 7 years) (21).

A recent analysis of GHB related emergency department presentations in Sydney recorded a **115% increase since 2015** (22).

Image: ABC News

21. Arunogiri (2019)
22. Harris (2024)

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INTERVENTION PRINCIPLES & EVIDENCE GAPS

Chemsex intervention principles

Evidence gaps

1. Scant evidence on community-based harm reduction practices relating to GHB overdose and sexual violence.

2. Implementation of diverse peer-led chemsex programs but few interventions documented or evaluated in the literature.

3. Barriers to service access are observed but there is little evidence on service experiences.

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LGBTQ+ INCLUSIVE PRACTICE GUIDELINES

- Asking questions about and recording data on sexuality and gender is important
- Avoid assumptions about gender, sexuality or relationship characteristics
- Be led by the person
- If you make a mistake apologise
- State your pronouns, ask clients theirs
- Develop referral pathways to LGBTQ+ specialist services

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M3THOD STUDY

- Qualitative study nested in a wider formative evaluation, designed to inform replicability & adaptation of a Chemsex peer-led service called M3THOD.
- Study period ran May 2022 – May 2023.
- Participants invited to complete a 60–90-minute semi-structured interview.
- Data for this study were analysed using a qualitative description methodology
- A mode of analysis often used in health services research aiming to investigate service experiences[8].

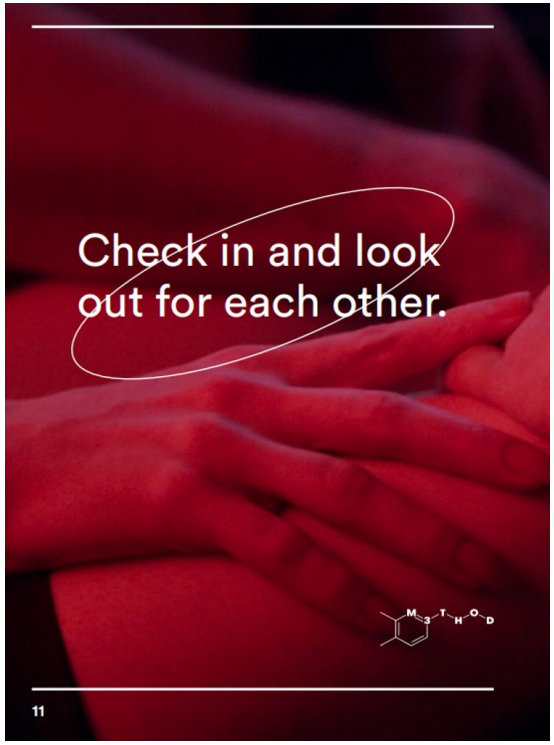
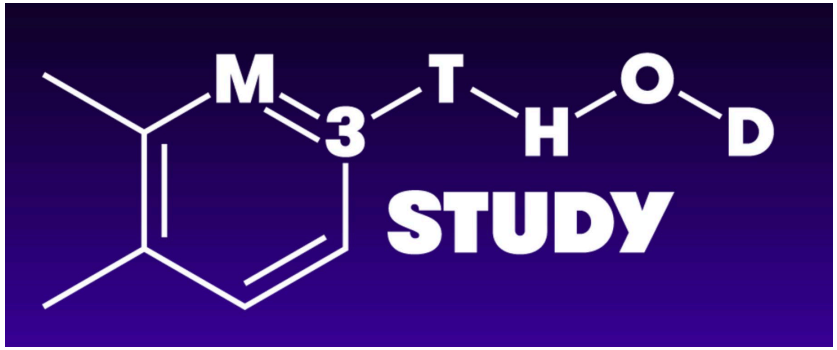


Image taken from ACON M3THOD harm reduction booklet

AIMS

Drawing on recommendations from empirical research that chemsex support services provide interdisciplinary care, this study aimed to investigate how those who practice chemsex, experience talk therapies across domains of drug use and sex.

We aim to outline how participants described their service experiences in relation to their treatment goals.



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PARTICIPANTS

Characteristics interview participants (n=24)

Gender	Cis male 22		Trans male 1	Non-binary 1	
Sexuality	Gay 21		Bisexual 3	Queer 1	
Age	18 – 29 2	30 – 39 4	40-49 8	50 – 59 4	60+ 6
Ethnicity	Caucasian 21		Asian 3	Latinx 1	
HIV Status	Negative 18		Positive 6		
Peer Service Use	Yes 18		No 6		
SDS for MA use >=4	Yes 18		No 6		

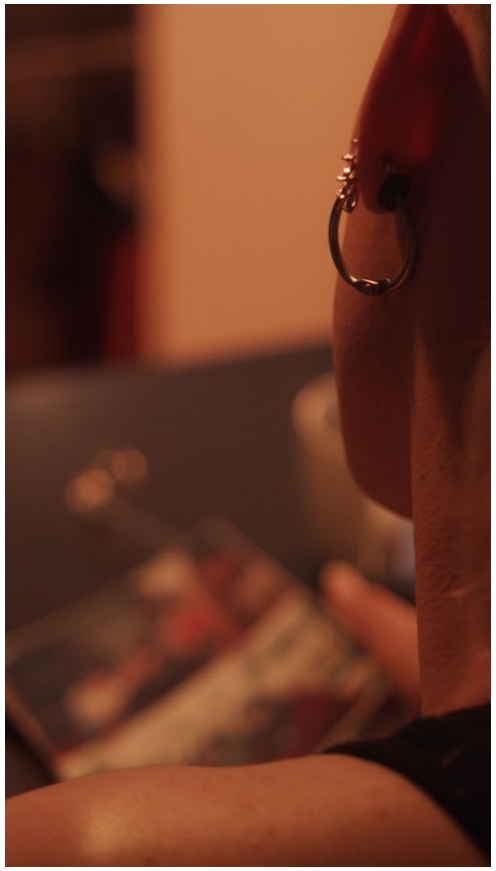
- **Eligibility:** GBMSM **or** trans/non-binary people reporting sexualized crystal MA or GHB use within 3 months, living in NSW.
- 24 people consented to be interviewed for the M3THOD Study.
- 19 reported injecting within last 3 months
- 18 recorded a severity of dependence score of greater than 4

SERVICE USE

Specialist & tailored services in inner city Sydney	**n = 12**
ACON Substances Support Counselling Service	6
St Vincent's Stimulant Treatment Program (specialist Drug and Alcohol Service)	6
Counselling via publicly funded sexual health service	5
General adult population services	**n = 14**
Counselling or psychologist services	13
Other AOD services (12-step, group program, residential rehabilitation)	6
No previous service use	**n = 3**

TREATMENT GOALS

- GBMSM reported a treatment goal of reducing or abstaining from methamphetamine use.
- Treatment goals were discussed with regards to patterns of methamphetamine use, the motivations underlining goals were improved mental health, relationships and social connection.
- At the time of accessing treatment participants narrated concerns about escalations in frequency, amount and duration of crystal methamphetamine use, or had experienced an acute incident.



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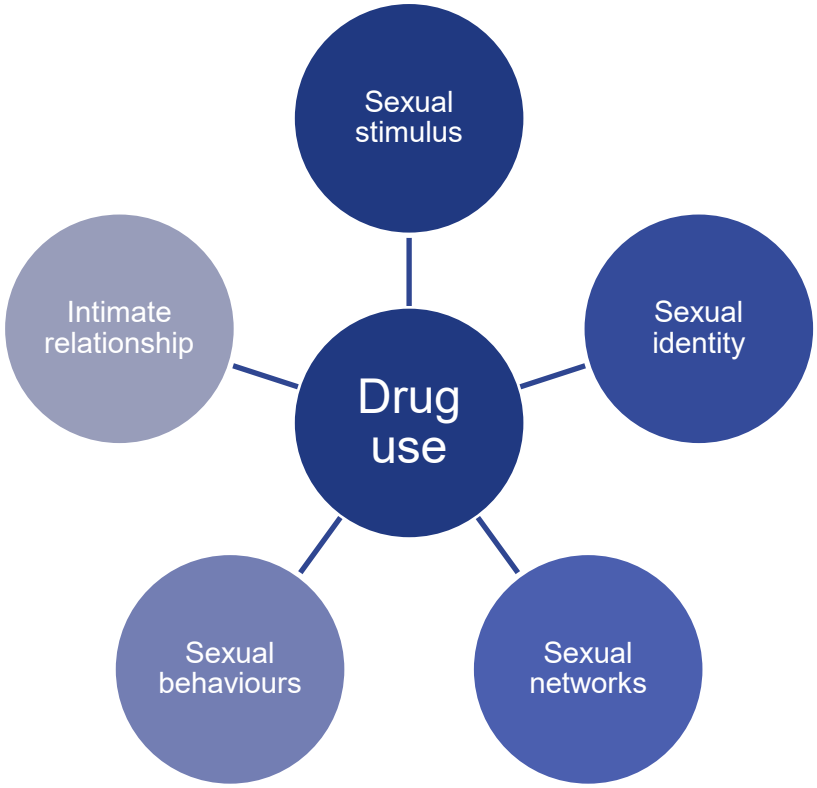
I had a big overdose from injecting. And that was then I realised the pivot, I realised now I needed to go and get help. "I need to take a break from this." And I think I just had to stop 'cause, if I don't, then I feel like it's gonna, I'm gonna get worse and worse, and I'm just gonna get to a point where I'll be injecting three points. And then that's when I'll be, I'll be down that rabbit hole, and I won't be able to get out.

- Michael, 20s

CONTEXT OF DRUG USE

1. Most GBMSM reported that they used drugs in sexual contexts and experienced a bi-directional relationship between their drug use, sexuality and sexual behaviours.
2. Departures from drug use were spoken about as departures from sexual identities, networks, intimate relationships
3. Many participants felt that learning to have sex without drugs would help them to reduce or abstain from their methamphetamine use.



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I can count on one hand the amount of times I've had sober sex. And I'm someone who has a lot of sex…. And the only reason why I inject is because one of the sex acts I enjoy is fisting, and I find it impossible to do without injecting…. And so, because many of my regulars now, that's how they know me, right, there's no way I could be like that sober.

- Dimitri, M3THOD client, 40s

One of the problems with my ex was that, when I was sort of weaning us off usage, then like I found it difficult to be physically intimate with him, which was a terrible thing to realise.

Jason, M3THOD client, 60s

I always used to say… "If I can learn to have sex sober, my battle has been won," because then I don't need the drugs, 'cause I'm using the drug to have sex. And sex is a human … To want to have sex is a human need.

- Sebastian, 40s

RESULTS

Most participants were not asked about sex when seeking services from counsellors or psychologists within services for the general adult population and reported barriers to disclosing sexual contexts and drivers of their drug use that were associated with anticipated stigma.

It's so focused on drug use and not the sex side of it, which like for me, when I think of the biggest reasons why I find it hard to give up is not because I want to have drugs every weekend. It's like, "Oh, but, if I'm not having drugs, I won't have sex." So, there's no conversation about the sex as a trigger in itself… And I mean, yes, drugs are the health issue, not sex…what I need help with is talking to someone about how I get confidence to have sex when, when not on drugs … I find whenever you ask for help it's, it's solely about reducing drug use. But they go hand in hand.

- Robbie, M3THOD client, 30s

CONCLUSIONS

Providers of talk therapies need to be supported to proactively ask about and address sexual wellbeing when providing services for GBMSM practicing chemsex.

There are very few theory-based approaches to addressing this relationship.

Despite a small number of practice examples recorded in the literature, there are no practices based on empirical data [23,24].

Applied research in this area is warranted.

23, Kunelaki R, 2019
24, Estrada J, 2008

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ACKNOWLEDGEMENTS

Thank you:

- To the 24 people who participated in interviews and supplied other data to inform this research.
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- To the CI teams and publication co-authors.
- To ACON, NCCRED & The Kirby Institute.

Delivering Inclusive & Affirming Services for People Who Practice Chemsex

Bo Justin Xiao, Glenn Noble, & Jack Freestone

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ACON SUBSTANCE SUPPORT

- Free short-term counselling(up to 12 sessions) for LGBTQ+ people seeking to manage, cut down or quit use of alcohol and other drugs.
- Delivered in person or online across NSW. Clients can return to the service at any time for additional support.
- Trauma informed, person centered and using a variety of evidence-based modalities – e.g. CBT, Motivational Interviewing, Acceptance and Commitment Therapy – within a harm reduction framework.
- Primarily funded by Central Eastern Sydney Primary Health Network (CESPHN)

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CLIENT DEMOGRAPHICS

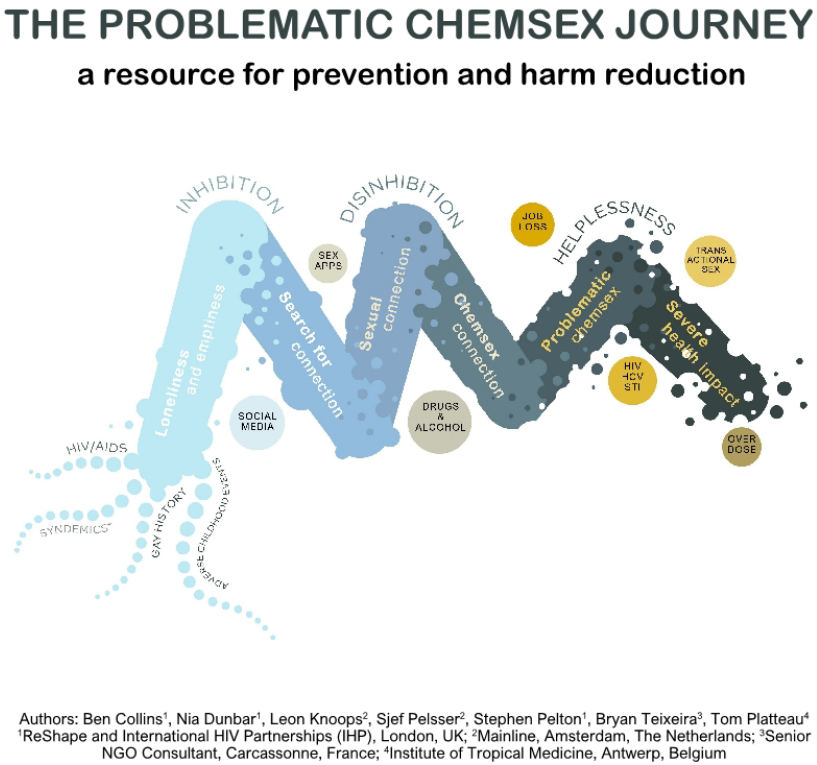
22% are living with HIV

80% cisgender men
5% cis women
5% trans women
4% non-binary
4% trans men

76% identify as gay
8% identify as bisexual
7% identify as queer
6% identify as lesbian
2% different identity

TREATMENT PRINCIPLES

- Affirming and celebratory of LGBTQ+ identities
- Person-centered and feedback informed
- Trauma informed
- Holistic
- Reducing Harms
- Addressing the experience of Stigma and Discrimination
- Responsive to the experience of Violence, Abuse and Neglect
- Recognises the co-occurring experience of AOD use and mental health conditions and symptoms and responds to both



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ADDRESSING SEX IN DRUG SERVICES

Empathise with ambivalence

- Acknowledge feelings of loss of identity and community + grief at the prospect of stepping away from chemsex.

Develop sexual identity & confidence

- Affirm sex positivity & diversity.
- Explore and understand internalised sexual shame.
- Use of therapy time to reflect on, identify and practice the articulation of sexual wants and needs.

Reframe expectations

- Challenge expectation of immediate adventure with new partners.
- Educate on the physical limitations of sex without drugs.
- Don't compare sex without drugs to sex with drugs.
- Acknowledge that sex without drugs may afford possibilities of softness, intimacy and relationship.

Experiment

- Explore the possibilities of applying practices learnt in chemsex contexts to sober sex.

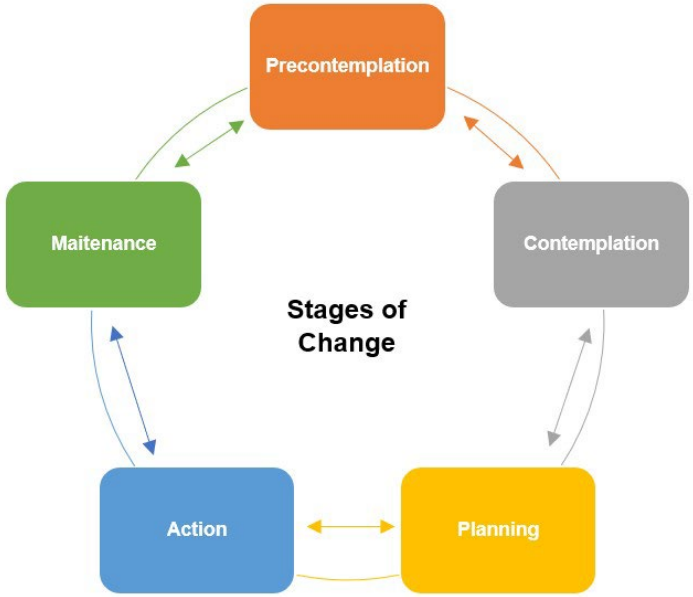
M3THOD PEER SERVICE

M3THOD devised in consultation with 16 people with lived experience, counsellors from ACON's substance support counselling team & researchers.

Based on stages of change theory M3THOD had three intervention components:

1. Harm reduction education
2. Motivational interviewing
3. Service navigation

Intervention aims: [1] Support people to reduce harms associated with chemsex, **[2]** manage the frequency of chemsex **[3]** access appropriate & affirming services.



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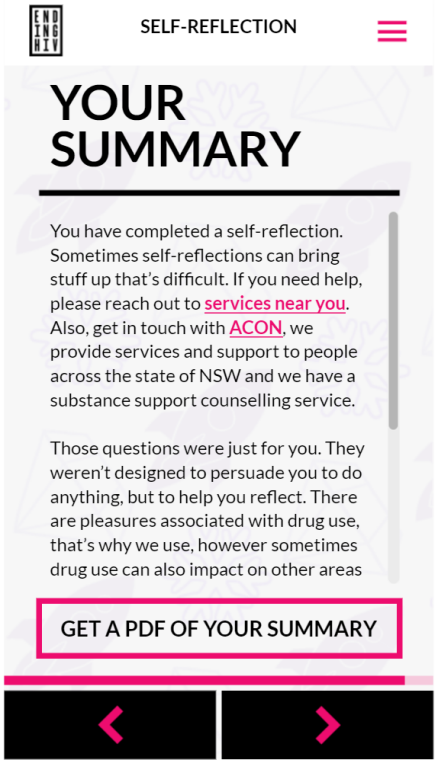
M3THOD PEER SERVICE

- 1:1 talk based brief (one time) intervention delivered in person and online.
- Delivered by three peers, each with living chemsex experience.
- Peers supported with tailored resources, ongoing training, ACON counsellors for debriefing and coaching and monthly clinical supervision.



ACON M3THOD Interactive resources
based on 56 Dean St, London resource

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M3THOD WORKSHOP

- A 6-week group program facilitated by peers and clinicians.
- For GBMSM who want to reduce the frequency of chemsex, and/or those who wish to stop using drugs for long periods of time.
- Built with a harm reduction approach, the workshop provides psychoeducation to participants on:
  - Stages of change
  - Trigger management
  - Shame and identity
  - Connection and intimacy
  - Value and boundary
  - Self-agency

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CLIENT SCENARIO 1 – ALI

Ali is a 24-year-old cisgender man who recently arrived in Sydney from Pakistan on a working holiday visa. He doesn't identify as gay or bisexual but has started having sex with men in the last year. Ali mostly socializes with other people from Pakistan, none of whom know that he has sex with men and many of whom believe that being gay is sinful. Ali's connection to sex is facilitated through Grindr and other hook-up apps. During a Grindr hook-up about 6 months ago, Ali tried meth for the first time. At the time he didn't know what he was smoking but felt an amazing rush and had great sex. After this encounter Ali met others online and he now parties on meth and G about once a week, sometimes more frequently. Ali has never sourced drugs himself; he only gets gear through sex partners. He enjoys the sexual possibilities that drugs afford and he finds that when using meth, he can have sex for longer and be submissive in a way that he and his partners find exciting. Ali has been referred to your service after a recent admission to emergency after a suspected GHB overdose. Ali doesn't remember the incident and doesn't know what GHB is. He's concerned that the incident happened and is now planning never to use drugs again.

Based on this description of Ali, your understanding of sexualized drug use and your personal clinical or other expertise, how would you work alongside him?

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CLIENT SCENARIO 2 – MATT

Matt is 42-year-old cisgender gay man, who has been using meth, GHB, poppers, ketamine and MDMA roughly every two months for most of his adult life. He comes to your service because a friend of his has registered concern about his drug use, noticing that over the past few year he's stepped up the frequency of his use. Matt has recently started injecting meth and parties most weekends, always for longer than 24 consecutive hours. Matt has come to the service mostly to appease his friend but also because he's noticed that he's started to miss days of work, he hasn't seen his family or siblings in over three months, and he's concerned about this. He's not sure that he wants to stop chemsex, he acknowledges just how much fun he has when he's partying and apart from his work worries and his friend's concern, he doesn't feel that there's many drawbacks. Matt indicates that he's just 'doing what all gay men do', he believes that all gay men use drugs and have lots of sex. He also has pronounced concerns about his body image and uses meth to stay fit. In Matt's opinion he's only got a few years left in his early 40s, after which time he will be "totally invisible" to the kinds of people he wants to have sex with. Matt can't remember the last time he had sex without drugs.

Based on this description of Saphire, your understanding of sexualized drug use and your personal clinical or other expertise, how would you work alongside her?

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CLIENT SCENARIO 3 – SAPHIRE

Saphire is a trans woman in her mid 30s. She lives alone in a rented apartment in the inner city. In your first consultation with Saphire, you learn that she uses crystal methamphetamine and GHB most days. Saphire is a sex worker and most of her clients request services involving drug use. Saphire grew up and previously lived in a regional area of NSW where she was employed as a truck driver. She moved to the city after affirming her gender. Throughout her process of gender affirmation Saphire lost several friendships, experienced transphobia within her family and at her workplace. Saphire discloses experiences around sexual violence, you also learn that Saphire has been diagnosed with conditions relating to depression and anxiety. In talking with Saphire, you learn that she has been to many counsellors, she's been referred between several different services and the process has left her feeling deflated. Saphire does not socialize with any other trans people.

Based on this description of Saphire, your understanding of sexualized drug use and your personal clinical or other expertise, how would you work alongside her?

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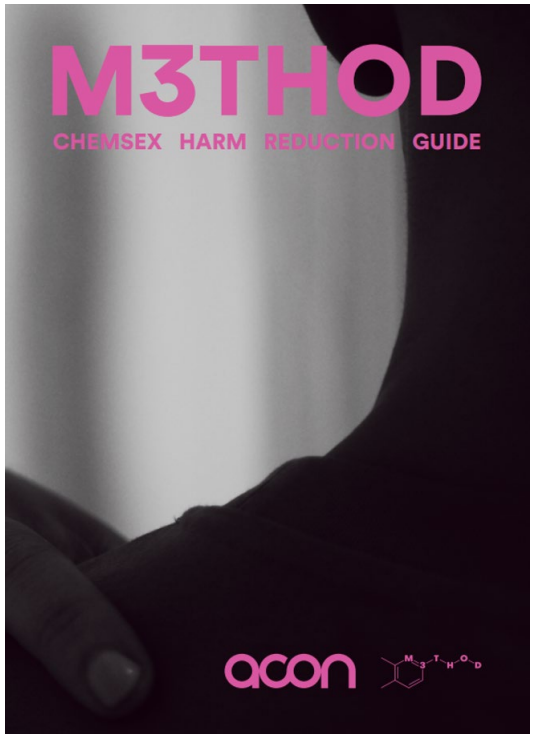
SUMMARY & RESOURCES



ACON, NADA & MHCC LGBTQ+ Inclusive Practice Guidelines