

MSM

Recreational drug use and sexual risk practice among men who have sex with men in the United Kingdom

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Do we know what's really going on?

The National Alliance of State and Territorial AIDS Directors (NASTAD) in the United States has described the increased use of crystal methamphetamine among men who have sex with men (MSM) as a "public health crisis."¹ However, outside the United States, evidence concerning recreational drug use and its implication in the rising rates of sexually transmitted infections (STI) and HIV among MSM is much more patchy.²⁻⁴ In the United Kingdom, data on changing patterns and practice of recreational drug use in the post-HAART era are incomplete, often disjointed, and generally inconsistent.⁵⁻⁷ If, as seems apparent from reports from other industrialised countries, there are important emerging issues concerning recreational drug use and MSM, then there is an urgent need in the United Kingdom to address the deficit in our knowledge. We set out a case for redressing the gap in our evidence base and propose simple strategies for developing better surveillance of this key behavioural aspect of STI/HIV transmission risk.

WHAT DO WE KNOW ABOUT RECREATIONAL DRUG USE IN MSM?

In North America and Australia the contribution of crystal methamphetamine and other recreational substance use to high risk behaviour is becoming an increasing focus of public health research.⁸⁻¹¹ Crystal methamphetamine (CMA) is a potent stimulant drug, chemically related to amphetamine. It is similar to cocaine in its euphoric effects; but CMA is more potent, much cheaper, and longer lasting (the half life of cocaine is 50 minutes while that of CMA is up to 12 hours).¹² Recent community studies have revealed important associations between the growing popularity of CMA and other recreational drugs and an apparent sexual culture shift towards more high risk behaviour.^{4 13 14}

Although prevalence of use in individual studies varies, there is substantial

evidence of widespread recent (3–6 months) non-injecting recreational drug use among MSM in the United States, including cocaine (10–25%), ecstasy (6.7–24%), CMA (6–14.3%), gammahydroxybutyrate (GHB) (1.6–4.8%), ketamine (4.2–5%), and Viagra (11.7–13%).⁸⁻¹⁰ Data from surveys of Australian MSM indicate even higher rates of recent use and an almost normative acceptance of recreational drug use in certain social and sexual settings.⁴ For example, investigators, in an ongoing community cohort study of HIV negative MSM, found that 61% of respondents felt strongly that "using recreational drugs is part of gay life in Sydney" and that 22.5% were concerned about their own recreational drug use (Dr Garrett Prestage, National Centre for HIV Epidemiology and Clinical Research, Sydney, Australia, personal communication).

These types of population level observations suggest that high rates of self reported recreational drug use are not restricted to particular socioeconomic, ethnic, or age groups, although US research shows that subsets of MSM are more frequent poly-drug users than others. For example, a San Francisco study found that 17.4% of STD clinic attendees had used CMA in the previous 4 weeks, with crystal users significantly more likely to report concurrent use of other psychoactive drugs and Viagra than non-users.¹¹ Other data from a six city intervention trial found that use of "newer" drugs, such as GHB and ketamine, was more common among younger than older MSM.⁹ In summary, these findings suggest that non-injecting recreational drug use among MSM in some large urban centres in the United States is widespread and evolving, both among specific subgroups and at population level.

In contrast, published evidence on levels and patterns of recreational drug use among MSM in the United Kingdom is scarce. Most behavioural studies report on drug use only as a secondary finding with little detail

about the types of drugs, drug combinations, or context of use. Consequently, there is almost no systematic description of the prevalence or patterns of use. The last published study to report widely the prevalence of individual recreational drugs in a community sample of MSM was the 1999 National Gay Men's Sex Survey.⁵ Among respondents in the London sample, 29.6% reported using ecstasy in the past year, 28.1% cocaine, 22.4% speed, 11.0% ketamine, 11.0% LSD, 2.5% GHB, and 2.5% "crack" cocaine.⁵ In recent years, behavioural surveillance surveys in London gyms have found key variations in the prevalence of recent drug use (unspecified) between MSM with self reported HIV infection compared to self reported HIV negative men (82% HIV positive and 66% HIV negative).⁷ Data from the 2004 wave of this survey showed that among 749 respondents, 21% reported using CMA, 49% ecstasy, 44% cocaine, and 38% ketamine in the past year.¹⁵ Use of ecstasy, cocaine, and ketamine at least once a month was common (16–24%), whereas only 6% reported using CMA with similar frequency. Limited though these data are, they should be enough to warn us of the potential for problems on the horizon—if they are not already with us.

WHAT ARE THE POTENTIAL IMPLICATIONS OF CHANGING RECREATIONAL DRUG USE AMONG MSM?

There are three reasons why we should be concerned about recreational drug use among MSM. Firstly, drug use culture is changing in this population. The current public health outcry about CMA in the United States largely derives from the social impact of the drug itself, its addictive potential, pharmacological characteristics, and evidence of outward spread from its historical, geographical, and social base on the West Coast.^{1 12} However, other less headline grabbing research has also described increasing poly-drug use, especially "newer" synthetic drugs among MSM and argues that the use of specific drugs may be less important than socialisation processes where recreational drug use becomes normalised within specific sexual and social settings.^{4 13 14 16} Therefore, focusing solely on a single drug such as CMA may be short sighted.

Secondly, while the general associations between substance abuse, sexual risk behaviour and STI have been documented since the 1980s, the nature of the relationship has remained unclear, confounded by contextual effects such as general or event specific use, role in anal intercourse, perception of partner's HIV serostatus, and partner

Key messages

- Growing international evidence describes evolving use of recreational drugs among men who have sex with men (MSM) and suggests independent associations with sexual risk
- In contrast, little is known of the extent and patterns of drug use and sexual risk practice in the United Kingdom, owing to lack of up to date systematic research
- We highlight the key issues of evolving recreational drug use among MSM and the likely need for health service interventions
- We propose simple strategies to improve local and national data and argue that sexual health services should take a leading role in developing the research agenda in this area.

type.¹⁷ Recent studies however, have found a strong correlation between substance use and sexual risk after controlling for potential confounders, showing the use of “party drugs” (including CMA, ecstasy, GHB, cocaine, and ketamine) before or during sex to be independently associated with unprotected anal intercourse with casual partners of unknown HIV serostatus, particularly among HIV positive men.^{8–11}

Thirdly, there is likely to be increased need for health service interventions to address the impacts of rising recreational drug use in this population, likely to require the expertise and joint effort of sexual health, mental health, and substance abuse professionals.¹ Sexual health services are a setting where MSM with problematic drug use are likely to present in significant numbers.¹¹ Although recreational drug use is an item on many genitourinary medicine (GUM) sexual history proformas, it is rarely discussed during routine clinic visits. Reasons for this are as obvious as they are numerous—clinical staff’s general lack of knowledge, time restrictions, and patient reluctance to discuss this sort of socially censured behaviour in a sexual health consultation. Yet in reality, sexual health services may be ideally positioned to provide basic advice on health promotion and harm minimisation. Most sexual health professionals, particularly the skilled cadre of health advisers in UK GUM services, possess the essential skills to offer early interventions involving counselling, education, and behaviour change support. This is a task that GUM, even under the current pressures, should not shy away from.

IMPROVING RECREATIONAL DRUG USE MONITORING TO INFORM STRATEGIC PLANNING AND HEALTH PROMOTION

However, in the absence of adequate information, we will continue to be

poorly positioned to decide whether, or how, to prioritise drug use interventions both at a local level, and in terms of a more comprehensive response within the National Drugs Strategy. Moves towards more client completed sexual histories may potentially reduce patient fears about disclosure and stigma, thus allowing collection of better data about sensitive behaviour.^{18–19} These improved data can provide local sexual health and drugs services with basic prevalence measures, and could flag up potentially important evolutionary trends in use over time. The information gap in what we know about trends within individual communities and what we need to know for planning purposes could be addressed with the addition of a small number of well crafted items to the battery of behavioural and needs surveys of MSM that take place across the United Kingdom.^{5–20–21} In addition, a small number of locally based qualitative studies, in London and outside, would have the added benefit of shedding light on sociological aspects of the intertwined dynamics of recreational drug use and sexual behaviour and could inform local health promotion initiatives.²²

CONCLUSIONS

Recreational drug use among MSM is evolving with the potential for significant physical and mental health impacts at both individual and population level. Long neglected in the United Kingdom, recreational drug use needs to become a research and surveillance priority. In light of the mounting international evidence, and in order for services to respond effectively, local and national prevalence and change in use data need to be collected and monitored over time. Better use of existing data and the addition of simple, easily implemented measures may go some way to addressing the basic information gaps and providing services with the appropriate data to act proactively. Capitalising on

their expertise and skills repertoire, sexual health services should take a leading role in developing the research agenda in this area.

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Chlamydia screening

Evaluating novel interventions for chlamydia screening

N Low

Useful adjuncts to a more general population chlamydia screening programme

Where should chlamydia screening be done? Who should be screened? How do we engage young men and vulnerable groups? How do we increase the uptake? Can the internet help? As a timely response to a recent call for innovative ways to encourage chlamydia screening in young people,¹ we publish two papers (pp 142 and 148) and a commentary (p 152) tackling some of these issues.

Götz *et al*'s pilot study in Rotterdam examined ways of encouraging chlamydia screening among African Caribbeans from Surinam and the Antilles (see p 148). In a previous population based study this group was at higher risk of infection than white Dutch people,² but less likely to respond to a postal invitation to provide home collected specimens for chlamydia testing.³ In this study, urine collection kits were offered by street outreach workers, or public health nurses providing sex education in vocational training schools. Participants could provide a specimen on site, or take a kit home with them. In the school and group settings uptake among the minority ethnic group was higher than in the postal intervention.³ The positivity rate in female vocational training school students was extremely high (27.9%, 95% CI 16.7% to 42.6%).

In contrast with targeting specific groups and settings, Novak and Karlsson set up an internet website to promote chlamydia testing to the whole adult population in one Swedish county (see p 142). Visitors to the site could request a test kit for home specimen

collection and mail it to a laboratory. About 60% of women and 40% of men requesting a kit returned a specimen. At a population level, this translated to about 3% of all women and 2% of all men aged 20–24 years having a test over an 8 month period. Both interventions included sexual health promotion. The authors of both studies suggest that their interventions could be useful adjuncts to a more general population chlamydia screening programme. In addition, Götz *et al* suggest that chlamydia screening in schools could help reduce chlamydia prevalence.

Before discussing where these new studies fit into the existing evidence, three basic principles need to be taken into consideration. Firstly, there are two approaches to chlamydia screening: systematic screening involves actively inviting the target population to be tested; opportunistic screening involves offering tests to people already attending a health service for another reason. The coordination, administration, and monitoring of the two systems are so different that they need to be considered as separate interventions. Secondly, chlamydia screening is part of a continuous programme that involves all steps from identifying the target population, through diagnosis, treatment, and partner notification of a high proportion of those eligible, to re-screening at regular intervals.⁴ Thirdly, according to the UK National Screening Committee, randomised controlled trials evaluating the intervention that will be delivered are required as evidence that a

screening programme will reduce morbidity or mortality,⁴ and, in the case of chlamydia, transmission.⁵

Studies on all aspects of chlamydia screening should ensure that they are designed using the most appropriate methods to answer the questions being asked

The first randomised trial of chlamydia screening found that systematic screening by endocervical sampling in women at high risk of chlamydia led to a reduction in pelvic inflammatory disease in the screened group 1 year later.⁶ More recently, systematic screening among female and male high school students in Denmark using self collected urine specimens was found to result in a similar reduction in the incidence of pelvic inflammatory disease.⁷ Opportunistic chlamydia screening, as practised in Sweden and the United States, and being rolled out in England,⁸ has not been evaluated in a randomised controlled trial.^{1 9 10} No trial has investigated the effects of screening on chlamydia transmission.

Taking these considerations into account, what do the studies published here contribute? Neither study involved randomisation or any control group so they cannot (and did not seek to) quantify any effect on primary outcomes of chlamydia screening. This is understandable in a pilot study such as that by Götz *et al*, but internet based promotion of chlamydia screening needs much more rigorous evaluation before its potential becomes clear. One of the settings for Götz *et al*'s study was vocational training schools. The core intervention was systematic screening, which is evidence based because schools were the setting for the Danish trial.⁷ The high participation and chlamydia positivity rates of female students from Surinam or Antilles in this Dutch study suggests that, in this age group at least, school based testing might promote engagement of a vulnerable group. As the authors say, this intervention is well worth studying in more detail. Chlamydia screening in schools alone,