Written evidence from David Stuart

1. My name is David Stuart, and I manage the substance misuse services and chemsex services at 56 Dean Street, sexual health and HIV clinic in London’s Soho (part of the Chelsea and Westminster hospital NHS Foundation Trust). I am also responsible for the clinic’s community engagement programmes, engaging those groups we consider to be at highest risk of sexually transmitted infections, including HIV and hepatitis C.

2. This submission is written in the capacity of my NHS Trust role.

3. I work in a centre of excellence that has a footfall of over 15,000 people each month, all accessing basic sexual health services, but also accessing behavioral support that accompanies sexual health testing and treatment. Behavioral support (when invested in) is the most effective forms of HIV and STI prevention we have at our disposal. Even preventative medicines and condoms require behaviour change support for them to be effective.

4. One of the most complex behaviours that challenges our ability to manage sexual health epidemics in any given city, is drug and alcohol use when it is used in sexual contexts; and especially so within groups where a higher prevalence of disease exists. It is challenging because people who are well-informed about safer sex methods, self-caring and who earnestly desire to avoid infection, behave in ways that contradict that when under the influence of drugs and alcohol. Some populations are particularly disproportionately affected by STI/HIV prevalence; and some populations are particularly disproportionately affected by drug use epidemics. There are always valid explanations for both associated with geography, education, poverty, historical trauma, poor parenting, mental health, poor experiences of sex and relationship education in schools, religious or cultural morals and stigmas... and access to healthcare.

5. I want to repeat; and access to healthcare.

6. There are always valid reasons for higher STI/HIV prevalence within certain populations, and there are always valid reasons for certain populations being disproportionately affected by drug use epidemics (despite some moralistic cries of self-indulgent drug use and reckless sexual behaviour).

7. Chemsex is the most prolific and epidemiologically different public health issue our healthcare services and policies have faced for a long time. It ticks the boxes of complex sexual behavioral problems as well as STI/HIV prevalence, as well as a unique and challenging drug use prevalence. Simply put, it is the reason cities around the world (that host large MSM populations) have been playing catch-up constantly with STI/HIV incidence, despite remarkable and effective advances in prevention methods, technologies and medicine. 56 Dean Street, where I work, has been successful in attracting and engaging London’s highest risk groups within MSM, hosting a chemsex behavioral support service since 2011. 56 Dean Street has an approximate 4,000 MSM who use “chams” accessing its services each month, with the consequences of complex sexual behaviour and choices that they struggle to understand. 56 Dean Street, by no coincidence, has also celebrated record and historic reductions in HIV infections – by a combination of (HIV) epidemic management methods that include robust chemsex
behavioral support positioned in the same building (and indeed, within the same consultation) as the sexual health consultation.

8. It has been argued, frequently, that gay men’s charities or substance misuse services could successfully carry the burden of chemsex behavioral support; that chemsex can be identified within a sexual health setting, and the behavioral support be managed in another part of town by a different service following a referral. It’s understandable how this might seem like a cost-effective and practical solution; please allow me to explain why this has been such a phenomenally unsuccessful model in regard to drug/alcohol use where it impacts sexual behaviour and drives STI/HIV epidemics.

9. **Scenario 1:**

a. A gay boy, 23 years old, goes to a sauna/bathhouse. His previous experiences of homo-sex included being ridiculed for being “too effeminate in bed”, even though he didn’t feel or know he was effeminate at all; he was rejected by many dozens of men because of a slim build and a tint pot-belly which probably had to do with too much beer. He drank too much of all the rejections, plus because pubs were the only place he knew to meet boyfriends or friends (and because he was a nervous type in those places) He lived in London where was no LGBT community centre. He also drank because beer helped with that religious echo in his head whenever he had homo-sex, shaming him for feeling aroused in this way. He had been vigilantly aware of HIV in every sexual situation he had been in; in fact he couldn’t stop thinking about it, the anxiety was present in every sexual encounter he had, unless there was enough beer in him. Grindr had been a series of cruel rejections for him, but he couldn’t talk to his mum or dad about it because (although they were accepting of his homosexuality) they couldn’t abide conversations about his dating life or sex life.

b. The sauna seemed a socially normal alternative to sex apps, though he perceived some judgment and expectations of his “sexual performance”, so when a person offered him some recreational drugs, he was particularly vulnerable to the invitation. The drugs were more effective than the beer. Over the next 48 hours, he lost track of time; he had the best sex he ever had, without the religious echoes in his head, and without hating his body as much as he usually did. He felt included and sexy, averse to the pain of rejection and like he was living inside a small bubble of time, where nothing really mattered. He relaxed and made friends (it seemed at the time), he forgot entirely about HIV, and he forgot about his belly. He also stopped being so vigilant about “masculine” behaviour, and let some of his camp tendencies to run free.

c. It was a mixed 48 hours; he did get rejected, he had cubicle doors slammed in his face, it’s possible that he might have slammed doors in other people faces too. He felt bad about that, but the drugs kind of numbed that, and he forgot very quickly. There were some racial slurs that hurt, but it seemed like all bets were off in this environment, in this bubble, so he ignored those. There was a moment when he “came to”, realizing he’d been very “high” on the drugs and that someone was having sex with him, but he couldn’t remember the previous thirty minutes. (Eight hours later, he sort of realized he was doing the same with someone else who seemed, perhaps, too high to consent. He stopped of course but; well he couldn’t think about that now, it was all too complicated.)

d. On Wednesday, when his friends asked how his weekend had been, he replied “Oh my gosh it was AMAZING!”
e. Some weeks afterward, at a sexual health clinic, a nurse identified that drugs had been a part of his weekly routine lately. She referred him to a gay charity in another part of town to talk about it, but he wondered why she was so concerned, when he had found such an effective solution to his problems, and especially since the consequences of his drug use were so minor; totally manageable. He ignored her and the referral.

f. Nine years later, there are greater consequences to his drug use; frequent STIs, a deterioration in his wellbeing; his mum hardly recognizes her little boy, blames gay life. He became HIV positive 3 years later; he was infectious for 18 months before getting diagnosed; he unknowingly and innocently infected 80 other men in that time with HIV (each of whom were also engaging in chemsex, multiple unsafe sexual situations and ignoring the referrals to addiction clinics).

g. The drugs had consequences, but the rejections stopped, the loneliness stopped, the feeling of ugliness stopped, and the religious noises in his head stopped. A decisional balance (drugs versus consequences) that he was happy with.

**Scenario 2:**

a. Same boy, same issues, same history, same sauna.

b. A different sexual health clinic; one that is still open (despite recent closures of sexual health clinics in the city); a clinic that is not referring asymptomatic patients to online home-testing kit websites. One that does not have its numbers of patients it can see capped by budget cuts.

c. One that is invested in by a government that understands the complex behavioral complexity of STI/HIV epidemics.

d. The boy comes (asymptomatically) for an HIV test to that clinic. Like the other tens of thousands of gay men in the city who are just like him. Just like him.

e. This time, during the HIV test, the nurse (who identifies the drug use as a risk factor in his sex life, in the city’s epidemic) says; “I’m pleased you’re enjoying your sex life; I get that the drugs help with that. Would you like to talk to one of our behavioral support workers, right now? Not about addiction, or abstinence from drugs, but about your sex life, how to be safer, and have more fun with less risks being taken?”

f. Boy says no, but he is taken aback by the attitude, and knows he is likely to continue engaging with this service.

g. In fact it has been a very long time since anyone had spoken so kindly about what his sex life might be like, and his right to enjoy it. His mum hadn’t, his dad hadn’t; those conversations weren’t normal in the environments he was frequenting.

h. The nurse continues; “If anything changes; if you do want to talk to someone about it; please know, that we won’t refer you to a substance misuse service, or to a therapist at a gay charity in another part of town; we understand that this is more about the challenges of gay sex in 2018, than it is about ‘addiction’; we understand that this is about Grindr and saunas, and gay sexual culture; and we have a team of people who really understand that and can have an easy chat with you, next time you have your asymptomatic sexual health check (or whenever you want to walk in)”.

He does return to the place he is familiar with; he avoids the high-threshold referral pathways that might otherwise have been the case, he avoids an HIV diagnosis, he avoids infecting 80 others with HIV (and the subsequent infections thereof), he avoids the other STIs he is vulnerable to and he moves on to have a sex life and love life that serves him well, serves his community well, and is the product of a culturally competent NHS that strives to end STI/HIV epidemics within its cities.

10. The above scenarios were not about tugging heart strings (though if yours were tugged, my heart goes out to you for caring). This is a story about excellence in NHS care, and about the effective ways in which HIV/STI epidemics can be effectively managed. It is a story about cuts to services, just as one of the greatest threats to sexual health epidemiology is finding it’s claws (I am speaking of chemsex, but also increases in drug/alcohol use by younger people in wider populations). London generally, and 56 Dean Street specifically, have created some historic and phenomenal reductions in HIV infections, saving many millions of pounds for the NHS, earning the NHS an historic reputation (the end of the HIV epidemic is in sight). I have watched my colleagues, over the last 9 years, innovate, strive and work tirelessly and creatively toward ending the HIV epidemic, but also in providing excellent care to most-at-risk groups; I’ve watched this work become an example to the world, a much-copied model of excellence. The cuts, already in place, are already being felt, as a major dent in our effectiveness, in our ability to care for these groups of people, to reduce the HIV/STI incidence within our cities. It is properly obvious to those of us working at ground zero, that we cannot maintain the successes in sexual health epidemiology, without appropriate investment, and with continued cuts to services and funds.

11. I truly appreciate you taking the time to read this; and for being aware enough of the issue, to invite this inquiry. That tells me you care like I do, and this heartens me. Thank you.

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