

## **HARM REDUCTION APPROACHES WITH SAME SEX ATTRACTED MEN AND WOMEN IN SYDNEY NSW, AUSTRALIA**

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Unfortunately, for people who were here to hear me talk about drink spiking, my talk is not about drink spiking, so I am in an unusual session here. There is a small section on drink spiking at the end of the presentation, but most of my presentation is actually about harm reduction approaches with same sex attracted men and women. What I will run through in this presentation is some brief information and some data on the levels of drug use amongst gay men and lesbians; some other anecdotal information that we know about drug use patterns with those constituents; I will talk briefly around drug use and sexual risk taking; then I will outline a couple of interventions that we have been working on, particularly around GHB, methamphetamine and drink spiking.

For people who do not know about ACON, ACON is the AIDS council of New South Wales. We are a health organisation, but predominantly based within the gay, lesbian, transgender and bisexual communities. We have a focus on HIV and AIDS, obviously, indicated by our title. But we do other things with gay and lesbian health issues, including drug use – which is obviously what I am here to talk about today.

I am not going to go into a great deal of detail about data, but I want to give people a sense of drug use patterns amongst gay men, lesbians and all same sex attracted people. This data is from a survey called *The Sydney gay community, periodic survey*, and it outlines drug use over a period of six months. Information about the survey just briefly: it is a self-administrative questionnaire; it is carried out every six months – so in February during the Mardi Gras festival in Sydney, and then again in August. Men are recruited from GPs, clinics, gay venues and social events. This data outlines in detail the level of drug use in gay men in the previous six months; the 2003 survey indicates that 46% of gay men had used amyl nitrite, 45% had used marijuana, 44% ecstasy, 29% used speed, 21% had used cocaine, and 12% had used crystal. We should note here too that, some of the men surveyed would classify ‘base’ or ‘ice’, and ‘crystal’ as speed, so once methamphetamines are included with the amphetamines, user level is fairly on par with cannabis – which is fairly high levels of use. You probably also notice there (referring to screen), a fairly stable line – so drug use patterns have not changed significantly for gay men.

With regards to injecting drug use, longitudinal data available suggests that, on the whole, the level of injecting drug use has remained stable over the years – albeit higher rates than the general population, based on the national drug strategy household survey. So for example, the Sydney gay community periodic survey indicates that about 5.4% of men had injected in the previous six months, compared to about 1.1% of metropolitan respondents in the national drugs strategy household survey.

I will try now to give a little bit of a context of gay men and drug use, and now what we know as recreational use is widespread as demonstrated previously. There is increasing evidence to suggest that the use of GHB is increasing, and I guess with the

use increasing, we are seeing it increasing in terms of problematic use for people, particularly around venues – but I will get onto that a little later on.

I guess there is a greater complexity in polydrug use, with a greater range of substances being used, so, there is a complexity around the mode of administration, and around the range of substances used to suit specific contexts, for example: party scenes, sex scenes, or the blending of the two. Then of course there are different drugs to assist ‘come-downs’ as well, so polydrug use can be quite complex.

Drug use is also strongly associated with dance and sex cultures, and there is some limited – though increasing – evidence to suggest that there is an increase in ‘crystal’ use. Now you will note that all that was about gay men, and I have got one slide for same sex attracted women, not because I left it out, but because the data is actually very difficult to find. The information that I do have is from the Australian longitudinal study for women’s health – which shows that recreational drug use is more prevalent among non-heterosexual women than heterosexual women, with about 58.2% of bisexual and lesbian women, aged between 22 and 27, reporting illicit drug use in the previous 12 months.

ACON, in collaboration with the national centre in HIV social research, in February this year did a survey called *SWASH*, which is Sydney Women and Sexual Health, it will be done every two years and that will give us a much better understanding of levels of drug use amongst women – but that was just done in February, and we do not have that data available.

I will move on now to drug use, gay men and sexual risk, which is tricky because episodes of risk taking, and especially sexual risk taking behaviour, is frequently attributed to drug and alcohol consumption; we hear this at ACON all the time, we hear it in our counselling programmes, our enhanced primary care project, we hear it in our groups that we run for gay men, and we hear it in our NSP. And it is also evident in some of the research, particularly research which researches gay men seroconversion - so when somebody has just recently contracted HIV, they are interviewed about what incident they thought contributed to their HIV seroconversion, and drugs and alcohol tend to be attributed in a lot of those cases; but I do need to say that we need to take care, because you cannot assume a direct causal relationship between drug use and sexual risk taking.

Social research in Australia particularly, has demonstrated little evidence of causality, despite a high level of association between drug use, sexual risk and other risk taking behaviours. Although the fact that drug use is so frequently sited as a reason or factor in risk decisions suggests that drug use may function as a disinhibitor, allowing the expression of desired behaviours or as a post-hoc justification. Thus drug use may function as a justification for, or a necessary pre-cursor to, an already determined abandonment of responsibility. So from a Health Promotion Point of View, what we may need to be addressing, is not the drug consumption per-se, but the factors motivating its use as a disinhibitor and the resultant behaviours.

I want to make the point, however, that drug use is not problematic for the majority of gay men. I do not want to stand here and paint a dreary picture of gay men and lesbians as chronic drug takers that are all problematic, because in fact that is not

actually true. And for most people, including gay men and lesbians, drug use ranges through from recreational through to problematic - and I define recreational by experimental, occasional use, and recurrent use, which does not affect health or well-being; but when I am talking about problematic use, I am talking about compulsive use or dependant use, with negative impacts on health and well-being.

(Referring to screen) The slide here represents, I guess, a continuum of drug use, and we need to keep in mind that users may continue to move along this continuum, while using, and that they may be at different points in the continuum while continuing with different drugs. So what I mean by that is that they may use Ecstasy recreationally and functionally, but their Crystal use may be problematic.

Matching clients to services depends on whether their use is chaotic or recreational. However, many services are located near the problem end of the spectrum, with limited services addressing drug use before it becomes problematic and difficult to manage. However, it is much easier to receive funding for programmes that address problematic drug use, but if we were to develop programmes to assist people in managing their drug use before it becomes problematic, then we may not need to spend so much money on treatment and rehabilitation programmes. There you go – it is a pretty wild idea.

I am going to outline now some initiatives that ACON works on around some of the different Party Drugs. Before I talk about the three different interventions here, I just want to outline some of the challenges that we faced, particularly around trying to develop programmes and interventions for GHB use. I guess it would be fair to say that ACON has been fairly highly criticised around a lack of response to GHB use, particularly when people first seeing problematic GHB use; we were criticised by party promoters, gay and lesbian community members, sex on premises venue owners (e.g. things like saunas, Sex Clubs, Back Rooms those sorts of things) and GPs. And I guess the criticism to some extent was justified, but I guess we were sitting there twiddling our thumbs, worried about what we should tell people about GHB and how to use GHB effectively, because what we heard from researchers and other people who knew a lot more than we did, was that it was very difficult to provide harm reduction strategies for GHB, because there really was a very fine line between a dose that would give a euphoric effect compared to a dose that is going to put you into a comma.

The other problem or challenge we face, and I mentioned this yesterday, was that with GHB particularly there was a lot of different agendas we had to balance and manage; so we had our own agenda, which was about improving health and well-being of the people that access ACON services; then we were working with licensed venues, whose agenda was obviously around their licensing, making sure they did not get Police raided, and there was a big dog issue at the time as well, so there were dogs all over the place raiding all over the bars and clubs, and I guess their number one priority is, because they are a business, they have to function and keep their license to enable them to operate as a business. The other agenda we are trying to balance at the same time is an agenda from accident and emergency departments - St.Vincent's particularly, which is one of the inner Sydney large hospitals, quite close to Kings Cross and Darlinghurst Oxford Street area, we are seeing increased people presenting

around GHB overdose, very unwell people, with sometimes up to four of five people intubated at a time, which meant they were in intensive care beds.

So all these agendas were being pushed from all over the place, and it was quite difficult to manage. It is also really difficult to find funding for any work around GHB; ACON particularly - predominantly our funding is still HIV dollars, and we can't spend HIV dollars on this type of work, so trying to find that money has been difficult. But I might say that one of the good things about people dropping on GHB, if there is anything good, is that for years we have been trying to talk to license venues about drug use in their venues and providing some information on how they can make their venue a safer venue; what we got before GHB came on the scene was just a brick wall, because, of course, 'drug use does not happen in my venue so why would I need to worry about it?' As people started becoming quite seriously unwell with GHB and ending up in hospital, the reverse actually happened and the venues came to us for assistance because they actually realised it was quite a serious issue.

So what have we done about it? Well, I guess it has been slowly but surely approach; we have been working with the *New South Wales Ambulance Training for License and Sex on Premises Venues Staff* because people were not just dropping in License Venues. What was happening was, they were going for a big night out and then going to a sex venue in the early hours of the morning and then dropping there. So it was not only the license venues, it was the sex on premises venues also, so that the ambulance officers provided some training for the venue staff. It was developed and it was actually modelled on the ARQ club, which Chris Curtis spoke this morning in plenary about, but it was a safety self-audit, so the venues have a tool with which they can actually assess the safety of their own venues. We are still trying to get together a bit of a print campaign inside the venues, and I guess the slow approach for the print campaign is around dollars; Chris has actually agreed to do a fundraiser for ACON to be able to do this work. I guess we could have found some money to do this campaign, particularly out of fundraised money, but I guess we wanted the venues to take some responsibility as well and actually contribute to a response to people using in their Venues.

We also have a fairly strong presence at quite large gay and Lesbian parties, like Mardi Gras for example. We have volunteer *Drug Rovers* at the major dance events, so what that is, two *Drug Rovers* in each of the large venues, whose job it is to just walk around to see if partygoers are well or unwell. I guess that began as quite a passive exercise, so the *rovers* just walked around checking to see if people were unwell, but we're trying to move forward with that one, and build upon it, and make it more of an active exercise so people are able to actually engage with the *rovers* for information. We provide a print message beforehand for most of the big dance parties, but I guess the main message is really around: looking after your friends, and if you feeling unwell, seeking assistance. We also provide NSP outreach to the major dance events including sharps disposal.

One thing I wanted to point out was that, with all of this work that we were doing, we came to the point where we realised that we were making drug use and partying really not fun; so we just painted this picture of 'you are going to get HIV from having too much sex, or your going to end up intubated at St. Vincent's hospital. So we are

trying to reframe it a little bit and make partying fun again, because the reason we go out is to have some fun, we do not actually go out for any other reason.

A bit of a baby in the making, which is a collaboration with the Red Cross - we are trying to build a relationship with the Red Cross with the aim of building a community response to the high level of drug overdose at gay and lesbian events. I guess as an organisation like ACON, we can intervene to a certain extent, but to have a really strong response, it needs to be a community response. So we are trying to get community members trained up, knowledgeable about drug use, identifying people who are unwell, as well as having a certified CPR certificate in case people need assistance.

Again, with methamphetamines it is really difficult to find money for, but we continue to put submissions in, and we have recently put another one in to undertake a rapid assessment of the scope of misuse. We desperately, and we have it written, we just need some money to develop and print, a print information resource and we also need to be able to (our Counselling Team particularly) increase their staff capacity to be able to work with people who are having problematic methamphetamine use.

The other thing I should briefly mention is that, in 2002, there was an increase in HIV notifications. For the first time in eight years, in 2003, we saw another increase, a smaller increase, but an increase on the increase. methamphetamines have come into the argument with that now - it is all *Meth's* fault and people screaming loudly about people on *crystal* having too much sex and getting HIV. It is something we need to manage, because I am not necessarily convinced that that is actually the case.

Drink Spiking (referring to screen) - these are the last two slides. This campaign was pretty much developed just before the *Gay Games*. We saw drink spiking happening in gay venues just before *Mardi Gras* in those sort of peak tourist seasons, and it tends to be overseas visitors who are by themselves, at a bar, who I guess can be seen as a bit of a target. What the campaign tried to do was increase awareness within the Gay Community of the incidents and the illegalities of drink spiking; because I do not think people got a sense that drink spiking actually was illegal. I guess two target groups there are people who actually may become a victim of drink spiking, but also people who are thinking of putting something in somebody else's drink. I guess we want to provide cultural specific strategies to reduce spiking. We also want to increase awareness of sexual assault services and that they can be accessed by men, I guess there was always a bit of a sense that sexual assault services were always for women; so we want to make sure that *Sexual Assault Services* are for men, and we also want to increase levels of reporting to get a sense of how much it was actually happening.

Now the data we used was actually from The Royal Prince Alfred Hospital, which is another inner city hospital in Sydney, which is where *Sexual Assault Service* is from. The project involved the police, the *Sexual Assault Services* and ACON; and the police were really good with this. The *Area Health Service* funded the first campaign, but the police actually paid for a second reprint, so that the police were really, really strongly involved in this.

This is the last one (referring to screen). This is the campaign itself. The one there on the far left is a drink coaster, the one in the middle there was actually a poster which

was inside the venues, and this one here - it was interesting that Paul said that those little cards did not work for women, but we call these cruise cards so what happens is that in gay venues, when somebody wants somebody's phone number, on the back of that card is a space for name, address and telephone number - so they do not just get the phone number, they actually get some information with that as well, and their actually really, really popular too.

Thank you