



## Centre for Social Research in Health

# Crystal Clear Podcasts

### **Episode 3 - What Workers Say: Health care professionals engaging gay and bisexual men using crystal for sex**

#### **VOICEOVER**

*Crystal Clear: Negotiating Pleasures and Risk around Sex on Crystal.*

This podcast series is part of the Crystal Pleasures and Sex between Men project.

Please assess your own capacity to listen, in case this podcast is triggering or upsetting to you.

This podcast is recorded on Bedegal Land.

The host of this podcast series is Tobin Saunders. Tobin is a proud, gay, HIV-positive health-educator and peer-activist. He's a longstanding and well-respected agitator for social change.

#### **TOBIN**

I'm your host, Tobin Saunders.

It's important that we can talk openly and without judgement about crystal methamphetamine. Crystal is commonly used in combination with sex among gay and bisexual men in Australia.

Today we will be talking to sexual health clinicians, harm reduction practitioners and those working in the alcohol and other drugs treatment sectors. The Crystal Pleasures and Sex between Men project identified an opportunity for workforce development between these three sectors.

We have guests on this podcast from each of these areas, and we'll hear from those who deliver services to find out the strengths and gaps in each area, and how they think they can work better together in addressing the needs of gay and bisexual men who use crystal for sex.

This excerpt is taken from an interview with Henry, a 59 year old man from Perth, talking about some of the difficulties he faced in sexual health service responses to his needs.

#### **EXCERPT**

*I guess it's knowing where to go for assistance, isn't it? Because it is so linked with sex. It should be through our LGBTI health service or somewhere like that. Or another separate place. Because at the moment, everybody is compartmentalised. You get moved from different group to group, because you don't fall into their box.*

#### **TOBIN**

First up, we'll hear from Carol. Carol is a consultant sexual health physician who has also done some research on chemsex practices among men who have sex with men in South Australia. How can services do intersectional care better?

**CAROL**

One needs to, sort of, look at what the situation is in different places in Australia. One thing that I have actually found in my research basically, is that it may be different with regards to, for example, prevalence and the characteristics of men who have sex with men and who engage with chemsex. And that may influence where they actually go to.

So, a lot of studies have shown that a lot of men who have sex with men typically use sexual health services, rather than substance use services. It is really, I believe, important that sexual health services and alcohol and drug services need to be able to collaborate a lot better to be able to capture this group of men who use chems during sex, who may want to look at, for example, harm minimisation and to actually stop - should they choose to.

I don't believe that one single organisation is able to actually do it all and there needs to be more collaboration.

**TOBIN**

Next, let's hear from Bram. Bram is an experienced AOD community service manager with Palmerston Association in WA. He is committed with working collaboratively in support of community needs and making services accessible to all.

Bram, what are your thoughts on this?

**BRAM**

It's important for services to build relationships between themselves. And I see that as very much an issue of leadership.

My observation is that in circumstances like this where the leaders of services collaborate and build relationships themselves, then that filters down into the quality of service provided to the people who come to the services for help. The overarching relationship building strategy starting at a leadership level and then filtering down through the various services components.

One key strategy that we've employed across a range of modalities is that we appoint local champions to lead the service response to the relationship building. And I think that has been a critical factor in improving the service that we do provide. The next level of that then, of course, is to engage the staff. Very early, engage them in basic education and bring them along so that they are aware of what is actually needed and what's happening.

One good example for us where we've done that is in the mental health area, which is certainly related to this discussion. A lot of clients coming to the drug and alcohol sector have co-occurring mental health issues. And historically there's been an issue of these people coming to a mental health service and getting directed to an AOD service, and then coming to an AOD service and getting directed to a mental health service. They're not getting their needs met.

So, what we've done is we've built very strong relationships with mental health services. We have shared care arrangements, we have trained staff in basic mental health assessment and treatment. Both sides of the equation in mental health and drug and alcohol have participated in this, and that has significantly improved the services provided to people coming to our services with these co-occurring needs.

**TOBIN**

Carol, what are your thoughts on this?

**CAROL**

So, I was thinking that perhaps we could involve drug and alcohol and get them to come over and talk to us a bit more about their resources, their harm minimisation techniques that they have. And

perhaps we could talk to them about PrEP use and STI care. So that they are able to give those services to men who do visit them.

I can talk about clinical settings. One of the things that we can use, and we might think about developing in collaboration with people in the future, is, for example, tools like including a simple set of questions to adopt to solicit information in clinical settings about chemsex, for example. That can be actually used in various clinical settings including drug and alcohol, including GP practices.

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## **TOBIN**

Like sexual health, the harm reduction sector is a crucial service in reducing the risks associated with crystal use especially for gay and bisexual men who choose to inject. But how does harm reduction fit in with sexual health and AOD treatment services?

Next we will hear from an interview with George, a 38 year old man in Melbourne.

## **EXCERPT**

*I think health promotion comes into play a lot in terms of creating a dialogue. Because the less it's talked about, the less context there is within our community and within communities where men have sex with men. We need targeted advertising and targeted health promotion. I also want to make sure that there's messaging around, "if you are struggling, we already know that you are using it". Like that's common knowledge now. We already have statistics and data to know that it's already happening. So for god's sake, talk about it! Because we don't talk enough about it. So I feel creating opportunities for people to be able to say, "I've got a problem" or "I just want to have a chat about it". Even the possibility of someone like myself turning around and going, "hey I'm thinking about using it".*

## **TOBIN**

Let's hear from Karl. Karl is the manager of Gay Men's Sexual Health Programs at ACON and oversees a range of projects supporting different communities, including people living with HIV and sexually adventurous men.

How can space be created to talk about the issues facing gay and bisexual men who use crystal for sex in a non-judgmental and in non-stigmatising ways?

## **KARL**

We understand that a lot of people, a lot of gay men use crystal just fine, so it should be a conversation around managing their use, and using more safely. At the other end of the spectrum, we'll have clients come through who are reporting issues with work or intimate relationships or friends and they may need a different kind of support.

Language is super important. Language when you talk about using drugs is certainly important and as health care providers, you know there's resources available. On the NADA website, there's a resource called "Language Matters" which kind of gives you recommendations around which words are kind of acceptable and not alienating and not stigmatising, and which words we might want to learn to avoid.

I think one thing I've probably learned in my work and in my own personal life and with my communities, is that language evolves, and it evolves very quickly. More broadly around, you know, transgender diverse populations and the appropriate use of pronouns. So, I think when you know talking to very specific communities, it's good to get your training in both AOD but also in community-specific kind of language. Because language is really important.

Being sex positive is certainly extremely important when you want to talk about crystal meth use and sex with clients. So you want to have a space that someone just feels comfortable and doesn't feel shame to speak up about exactly what they enjoy and what they get up to. Because if you don't kind of have that as a base line, it's going to be kind of hard to authentically explore problems and create support structure for someone. So sex positivity is definitely a big part of it.

**TOBIN**

Next let's hear from Adrian. Adrian's background is in clinical psychology with over 20 years' experience. He works as a facilitator and educator and has been developing mindfulness in session-based techniques to help gay and bisexual men managing their crystal use.

Adrian, what are your thoughts on this?

**ADRIAN**

I think in my own experience I've learnt a lot from the men I've worked with who are using for lots of different reasons.

And that leads to another important point I think for the work force, and that is to consider that not every methamphetamine user is exactly the same. There may be some common features around challenges and problems that people are facing, but people use for different reasons. As we know, that can vary to someone who is using a couple of times a week to someone who is using once a month, and their perspective often around the drug is that they've got control, the drug hasn't got control of them.

So, I guess along the continuum there's various intensities that we see, and I think we just have to make room for that. We have to have a sense of understanding and everybody's different and to illicit a sense of where this person is at. What are the current needs and wants of that person, and also what resources they've currently got?

We may not always get answers in the first session. In the second session, in fact! And as a clinician, this is one of the things that I have tried to do better. So instead of trying to fix the person in front of me—which a lot of clinicians are trained to do this and it comes from a good place, we are generally compassionate people, we want to help, we want to get rid of the pain that people are in. But the one hurdle in front of that is if the person isn't quite ready yet to change.

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**TOBIN**

Finally, the AOD sector is a lot broader than just residential rehab or abstinence based programs.

Let's hear an excerpt from an interview with Dale, a 43 year old man in Sydney.

**EXCERPT**

*So the treatment centres that I go to, I say "well what I kind of want to better understand is the co-existing of sex addiction and drug addiction and I'd like to be treated for the two. But it's still taboo, it's still not understood. Like from my experience, gay men, sex and drug treatment is not well known in the alcohol and drug field. They need an understanding that crystal is a sex drug, so I can assume that it would better understood when I went into treatment. But it didn't seem like it was understood. And I think it's still covered in shame or it's taboo.*

**TOBIN**

Bram, how can we engage other services to bring in other expertise when needed?

**BRAM**

There are a number of ways that services can respond to this question. One particularly useful strategy, I think, is the use of outreach services. From our perspective, that would mean a drug and alcohol worker working perhaps a day a week in another agency, providing the specialist drug and alcohol service, but working in with the team and the workers in that agency. That enables our worker to gain knowledge and understanding about that agency, and the people coming to it, and also then provide the expert AOD service onsite. And we find that in some cases people prefer to come to agencies they are familiar with and if we've got a worker there, they are more comfortable engaging with them.

Having clearly established referral pathways between the services is really important. Meaning if someone comes to a particular agency and that agency needs AOD support, they can ring up an AOD service, know who to talk to and get that kind of consultation directly. That's often backed by arrangements - we call them service level agreements or memorandums of understanding, which are higher level, but it's sometimes backed with a written commitment to engage in that relationship type of work.

Another really good example, a way to engage other services is to engage in reciprocal education. And that would involve a clinician or a coordinator perhaps from an AOD service going into a mental health service or, in this case, in an LGBTI service, and providing some education about the sort of work that we do and the approaches we take and the sort of things we see and then vice versa. That education is delivered to the staff groups. That's quite a crucial vital way of maintaining a relationship, sharing skills and knowledge in keeping the pathways open.

Another example is related to this is called "shared care arrangements". Perhaps a practitioner from two services work together in the support of someone who's come for help. So in this case, if someone came who is using crystal meth, if a client came to an LGBTI service who is using crystal meth, and needing some support then perhaps the practitioners in that service could engage with someone from our service and provide either something as creative as perhaps joint sessions or certainly a joint shared care arrangement to help that client as best we can.

## **TOBIN**

Finally, for this podcast is Gareth, originally from Wales in the UK, Gareth has worked in Palmerston in WA for 10 years and he's currently exploring ways to improve the inclusion of LGBTIQA plus communities into AOD services.

Are there any workforce development needs that need to take place to better address the needs of gay and bisexual men in all their diversity?

## **GARETH**

The funding climate that we're existing in at the moment as an AOD service doesn't lend itself to sharing clients, referring people out. I think a lot of the time the organisations want to keep all the clients they've got. But sometimes it's really useful and helpful for the client to acknowledge the fact that maybe another organisation can do a better job in this area or this person's life and not being too proud to admit that and looking at the bigger picture.

What we do quite well as a service is a lot of what we would call a "warm handover" to a lot of other services. So, trying to build client's confidence in going to another service and being that kind of liaison between the service and the client. As much as possible, giving as much information or as much as the client wants us to give, and trying to support the client as much as possible in transitioning to a service that might be a little bit more suited to the issue that they're bringing to us.

## **TOBIN**

And I guess that could be sensitive too, because you have confidentiality and you have clients that may be needing to share their story over and over again as they get support from different agencies?

**GARETH**

Yes sure, nobody wants to repeat their story to 6 or 7 different people. So those kind of “warm handovers” are always done with permission of the clients. And most of the time, people agree to that kind of warm handover due to the fact that they don’t want to keep on repeating their story over and over again.

**TOBIN**

So Bram really, the sectors are not as siloed as many of us might be led to believe?

**BRAM**

Not in my view, no.

I’ve been in the sector almost 20 years now and when I came into the sector, I certainly did observe that. But we’ve made positive steps to address that over those years. And I’m talking about mental health obviously, particularly in that area, but the relationships between the various service arms have improved and are very productive in my view.

In the area of working with the LGBTI community, we’ve got work to do. I’m certainly not disputing that. But we have started that work and I see very, very positive evidence of drug and alcohol services engaging in various ways with services that support the LGBTI community. I’ve got numerous examples of where we have, but I can certainly verify that that work is underway now. That there is a level of interest in that now and a level of awareness.

**TOBIN**

What do you think then Gareth?

**GARETH**

We, as an organisation, have done quite a lot of training around meth as a specific substance and consulted with lots of other organisations about supporting people that use meth.

An initiative that we arrived at, was to establish what we call “a meth clinic” that was designed to support users through case management, pharmacotherapy and cognitive behavioural-based therapy group work. We’ve also allocated one of our experienced clinicians as a meth specialist clinician.

**TOBIN**

Thanks so much Gareth. Is there anything else you would like to add?

**GARETH**

Yeah, there is actually, Tobin. One thing that I really wanted to get across to anybody who’s listening is don’t be afraid to ask the questions, even if we don’t have all the knowledge around the gay or bisexual experience or the knowledge around crystal meth and how it can be used for sex.

The most important thing to remember is to be curious and be genuine, and if you don’t know an answer to a question, then don’t pretend you do. I think that genuineness can really do a lot to build rapport and to keep a person engaged.

We try and encourage people to go to as much or as many of the organised events that happen outside of office hours, like Pride March and Fair Day that we have in Perth. Being visible in the community in the LGBTI community, getting the organisations name out into the community as some way that understands inclusivity, understands diversity.

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## **TOBIN**

The data from the Crystal Pleasures and Sex between Men Project demonstrates there is a perception that the wider sector is divided into specific service responses. For example, sexual health, harm reduction, AOD and blood borne virus prevention. We need to challenge that view by looking to where intersectional support has occurred or has the potential to occur. It is important that the strengths of each sector are used to augment what others do.

Gay and bisexual men's use of crystal for sex could be understood as chemsex. While chemsex has become shorthand for drug enhanced sexual activity (and some of our guests may use this term), we have chosen not to use this term in our research. Chemsex can often refer to specific settings and practices that are automatically deemed risky. And we feel it is important that we don't make assumptions or leave out other aspects of Australian men's experiences.

But there are particular challenges that sex on crystal presents for the healthcare sector. Gay and bisexual men's experiences are different from other drug dependencies. We need to emphasise the need for culturally competent services.

## **VOICEOVER:**

You've been listening to *Crystal Clear: Negotiating Pleasures and Risk around Sex on Crystal*.

This podcast is produced by the Centre for Social Research in Health at UNSW Sydney in partnership with ACON, Thorn Harbour Health, South Australia Mobilisation + Empowerment for Sexual Health and Western Australian Aids Council.

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We would like to thank our guests, partners, collaborators and funders.

If you are worried about your or someone else's crystal use, please refer to the information on the website for help. Support is available should you need it.

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