

1 **Sexualised drug use in people attending sexual health clinics in England**

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27 Recent evidence highlights an increase in ‘chemsex’, the use of recreational drugs during
28 sex, in men who have sex with men (MSM) and an association with risky sexual behaviours
29 and outbreaks of sexually transmitted infections (STIs).¹ However, the extent of sexualised
30 drug use in people attending sexual health clinics (SHCs) is unknown.

31 STI surveillance in England is performed by Public Health England (PHE) using a
32 disaggregated patient-level dataset of all diagnoses and services at SHCs.² This is a
33 minimum dataset with key demographic and clinical variables, but lacks behavioural data. To
34 address this gap, PHE piloted a surveillance enhancement to collect behavioural data,
35 including sexualised drug use (an affirmative response to ‘were you under the influence of
36 recreational drugs [before or during sex] with any partner in the last 3 months?’). A pilot in
37 six SHCs throughout England took place from August 2013 to April 2014; at each clinic,
38 attendees’ behavioural data were collected for all new patient episodes.

39 Complete data on 8,741 attendances were submitted (48.5% of eligible attendances).
40 Overall, the proportion where sexualised drug use was reported was 6.6%, ranging from
41 4.1% in heterosexual women to 12.1% in MSM. Among the 519 MSM who reported at least
42 one sex partner in the last three months, the most commonly reported drugs used before/
43 during sex were mephedrone (10.4%), γ -hydroxybutyrate/ γ -butyrolactone (GHB/GBL, 7.1%)
44 and cannabis (6.7%). Chemsex is usually associated with mephedrone, crystal
45 methamphetamine or GHB/GBL¹ and, among MSM who reported using them before/during
46 sex, the proportion who injected ranged from 7.4% (4/54, mephedrone) to 42.1% (8/19,
47 crystal methamphetamine).

48 These preliminary data suggest that sexualised drug use is commonly reported by SHC
49 attendees, especially MSM, and highlight the utility of monitoring drug use at SHCs to
50 identify local needs and plan care pathways for appropriate treatment services.

51

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60 coordination. The GUMCADv3 Steering Group was responsible for designing and finalising
61 the data specification for the pilot. HM wrote the first draft of the manuscript and performed
62 the analysis with JW and CK. All authors read, critically reviewed and approved the final
63 version of the manuscript for publication.

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