Improving Substance Use Related Policies for Gay, Bisexual, and Queer Men

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Summary

Licit and illicit drugs are often used by gay, bisexual, queer, and other men who have sex with men, both cisgender and transgender (GBQM), to (1) facilitate social connection and bonding; (2) enhance sexual desire, performance, longevity, or pleasure; and (3) diminish unwanted feelings of sadness, worry, and poor self-image. Among these men, substance use during sex frequently includes the use of non-opioid drugs: crystal methamphetamine, alkyl nitrites (also known as 'poppers'), ecstasy, ketamine, and gamma-hydroxybutyrate (also known as 'GHB'). Elevated use of these and other drugs, poor service delivery, and the stigmatization and criminalization of drug use, puts GBQM at increased risk for physical and psychological social challenges, illness, injury, and death. To address these challenges, we recommend the inclusion of sexual and gender minorities as a key population under the *Canadian Drugs and Substances Strategy* and the establishment of an independent Law Commission of Canada to provide comprehensive recommendations for revisions to the *Criminal Code* and *Controlled Drugs and Substances Act* that will reduce and prevent harms among and against GBQM.

Problem statement

Challenges for substance use related prevention, treatment, and harm reduction among gay, bisexual, queer and other men who have sex with men, both cisgender and transgender (GBQM), are threefold:[1] (1) the prevalence and nature of substance use among GBQM differs from that of non-GBQM; (2) differences in healthcare delivery and access for sexual and gender minorities make mainstream services less effective at addressing the needs of these populations (especially because sexuality is often not discussed), and (3) poorly regulated drug markets pose an intolerably high level of risks to GBQM due to their distinct and elevated patterns of use for some drugs. Below we briefly summarize key points for each of these three challenges.

Prevalence and nature of substance use among GBQM

- While stigma against GBQM and other people who use drugs makes it difficult to precisely measure the prevalence of substance use, studies consistently show that GBQM are more likely to engage in substance use[2] – with differences emerging in adolescence and early adulthood.[3]
    - For example, sexual and gender minorities are nearly twice as likely to use opioids "intensively" compared with heterosexual persons.[4]
    - Additionally, sexual orientation has also been linked to nearly a fivefold increase in the risk of fatal drug overdose.[5]
- In addition to increased use, motivations for substance use among GBQM arise from unique stressors related to their experiences of social exclusion and discrimination, which stem from the social stigma that GBQM continue to experience in Canada today.
    - These motivations include desires to facilitate social connection and bonding; enhance sexual desire, performance, longevity, or pleasure; and diminish feelings of sadness, worry, and poor self-image.[6–9]
- The types of drugs used by heterosexual men and GBQM are also different[10] – particularly with regard to sexualized drug use, which is sometimes referred to as "chemsex" or "party and play (PnP)", and includes the singular or concomitant use of crystal methamphetamine, alkyl nitrites (also known as 'poppers'), ecstasy, ketamine, and gamma-hydroxybutyrate (also known as 'GHB').[11]
    - Studies show that more than 20% of GBQM engage in patterns of recent polysubstance use (past six months), with often concurrent use of "party drugs".,[12]
    - Notably, GBQM are as much as 20 times more likely to use crystal methamphetamine,[13,14] which is often administered through injection (positing risk for blood borne transmission of infections such as HIV and Hepatitis C virus), highly addictive relative to other illicit substances,[15–17] has few effective treatment options,[18] and is increasingly common (as indicated by a 590% increase in possession-related charges between 2010 and 2017).[19]

Differences in healthcare delivery and access for GBQM

- Despite the elevated prevalence of substance use among GBQM, access to health and addictions services for GBQM is generally poor, with less than 10% of GBQM reporting access to substance use treatment programs worldwide.[20, 21]
    - Barriers to access include lack of availability (particularly in suburban and rural areas), non-approachability (e.g., some treatment programs might be non-

approachable due to bias against GBQM or may not include considerations of sexual orientation), non-acceptability of services offered (e.g., abstinence only programs may be difficult to adhere to), unaffordability (e.g., lack of mental health/substance use treatment coverage), and shame/embarrassment about substance use.[21,22]

- Therefore, most substance use disorders experienced by GBQM go untreated.[23]
- However, improved access to treatment programs has been correlated with increased access to HIV risk-reduction education, mental health services, medical care, and higher levels of connection to lesbian, gay, bisexual, transgender, queer, and Two-Spirit communities – suggesting that providing integrated care services through GBQM-tailored organizations could improve treatment access and utilization.[20,24]
- Importantly, GBQM-affirming programming has been shown to produce better treatment outcomes.[25]

Existing drug markets pose an intolerably high level of risk to GBQM

- While the sudden increase in opioid-overdose related deaths has called attention to opioid-related drug harms, there continues to be a need to manage the epidemic of crystal methamphetamine use among GBQM and other people who use methamphetamine.
- Indeed, along with greater polydrug use among GBQM, lack of focus on these substance use behaviours places GBQM at higher risk for drug-drug interactions which can result in overdose.[26]
    - For example, erectile dysfunction drugs are often used to counteract the adverse effects of crystal methamphetamine and ketamine during chemsex events;[27,28] but when combined with poppers (another common chemsex drug), individuals can experience a drop in blood pressure, stroke, or heart attack.[29]
- Furthermore, elevated use of drugs such as ketamine and methamphetamine among GBQM suggest that the expansion of fentanyl and its analogues into these drug supplies could soon contribute to a dramatic increase in overdose morbidity and mortality among GBQM.
    - Local and international experts studying the overdose epidemic, which is predominantly driven by a contaminated drug supply, have made calls for increased naloxone distribution,[30] supervised consumption,[31] drug testing,[32] safe drug supplies for potentially tainted drugs,[33] opioid agonist therapy,[34] and decriminalization of personal possession [35–37] as the most effective strategies for addressing overdose and preventing the transmission of HIV. These, and likely other, interventions are needed to avert harms and risks to GBQM.

Legal and policy options

Substance use related harms to GBQM and other sexual and gender minorities are complex and multifaceted. As such, remedying these harms will require broad considerations of existing Canadian substance use policy. In the following paragraphs, we consider substance use policy within the context of the *Canadian Drugs and Substance Strategy*, *Criminal Code*, and the *Controlled Drugs and Substances Act*. Changes to these statutes and strategies provide the most effective means of improving GBQM health when it comes to their substance use.

Revisions to the Canadian Drugs and Substances Strategy
In December 2016, the Government of Canada announced the new *Canadian Drugs and Substances Strategy* (CDSS). Among other things, the CDSS:

- replaced Justice Canada with Health Canada as the ministry responsible for leading the Government's response to substance use;
- re-introduced harm reduction as one of the Government's key response strategies;
- clarified its aim to address the opioid overdose crisis and the challenges of legalizing and regulating cannabis; and
- included a variety of programs and infrastructure for addressing substance use among key subpopulations, including youths, First Nations people, and Inuit people.

However, even though these are laudable efforts to improve Canada's substance use policy, no specific strategies, infrastructure, or funding are explicitly mentioned to address substance use concerns among GBQM and other sexual and gender minorities. Moreover, the CDSS lacks focus on several key psychoactive drugs that are disproportionately used by GBQM, such as crystal methamphetamine, poppers, ketamine, ecstasy, and GHB.

Recognizing these and other deficiencies in the CDSS, Health Canada opened a 90-day (September 5th to December 4th, 2018) public consultation on the CDSS. With this consultation now closed, future revisions to the CDSS strategy are expected – providing an opportunity to introduce strategies, infrastructure, and funding to address the unique needs of GBQM and other sexual and gender minorities who use drugs. Such improvements might include providing dedicated resources, treatment networks, and surveillance strategies for substance use prevention, treatment, and harm reduction for GBQM,

Revisions to the Criminal Code and Controlled Drugs and Substances Act
In addition to revising the CDSS, there is also a need to address the underlying structural stigma associated with substance use. Health Canada recognizes the harmful effects that stigma has on people who use drugs and has expressed a desire to address substance use related stigma. According to Health Canada, *"Stigma can be defined as the negative attitudes and actions directed toward a group of people due to their circumstances in life, including judging, labeling, stereotyping and exclusion."* [38]

This definition, however, does not explicitly feature the role of the *Criminal Code* and the *Controlled Drugs and Substances Act* (CDSA) in creating, perpetuating, and constantly reinforcing stigma against people who use drugs. Indeed, under current law possession of a Schedule I drug such as methamphetamine can result in up to 7 years' imprisonment and trafficking such a drug can result in a lifetime prison sentence. Previous changes to the CDSA have specifically targeted GBQM, including the ban on poppers in 2013.[39] Though criminalization of drugs is itself a by-product of social stigma and paternalism, laws criminalizing personal possession of drugs readily reinforce the negative attitudes that Canadians have of those who transgress these laws. There is now a growing body of evidence suggests that liberalization of drug policy can reduce stigma against people who use drugs and have shown that such changes are associated with a number of health improvements that are unlikely to be offset by the relatively few people who might uptake drugs due to a change in their legal status.[35,36,40,41]

Nevertheless, multiple models of substance use liberalization exist.[35] For example, Portugal partially decriminalized personal possession of drugs in 2001 following a multi-year in-depth study by a federal commission tasked with curbing overdose deaths. Under this long-standing system, drug use remains illegal, but results only in small administrative fines rather than criminal convictions. Since this change was introduced, there has been significant declines in the incidence of HIV, other sexually transmitted infections, and deaths related to overdose.[38] The Portugal model is increasingly viewed as a framework for countries, like Canada, hoping to establish a more compassionate and evidence-based drug policy.[42,43] The growing evidence base provided by global policy liberalizations may provide an opportunity to further improve substance use policy. To date, exemplary steps towards liberalization include:[35,36,44]

- The *Good Samaritan Drug Overdose Act*, which exempts individuals who call emergency services for an overdose or are present when first responders arrive from simple possession charges and charges related to violations of an individual's conditions of probation or parole.
- Deregulation of prescription-grade drugs (e.g., Methadone, Suboxone/Naloxone) to allow doctors to prescribe these drugs under Health Canada's Special Access Program.
- Increasing availability of harm reduction supplies, including supervised consumption, needle exchanges, crack/meth pipes, and thermometers (to avoid overheating).

Beyond these examples, there remain multiple opportunities to pioneer other activities to reduce substance use related harms (e.g., establishment of safe supply vending in more socially acceptable venues such as social clubs or sex-on-premises venues). These and similar provisions made available by revisions to the *Criminal Code* and *Controlled Drugs and Substances Act* have the potential to greatly reduce many of the criminalization-related harms that disproportionately impact GBQM (e.g., HIV and other sexually transmitted infections)[43] and could prevent other health inequities from taking hold among GBQM who use drugs (e.g., overdose deaths, should drug supplies for more commonly used drugs become contaminated by fentanyl or similarly harmful compounds).

That said, the long-term implementation for these harm reduction measures – regardless of what immediate actions might be taken to ensure a safe supply for people who use drugs – will likely require careful scientific expertise. As conservative Nobel prize winning Economist Milton Friedman said 30 years ago, in 1989,[44] "*Postponing decriminalization will only make matters worse, and make the problems appear even more intractable."* Indeed, the public health emergency surrounding Canada's contaminated opioid supply explicitly affirms Friedman's urging for decriminalization and highlights criminalization as a longstanding challenge in public health. While there are many barriers to be navigated, the work of decriminalizing drugs provides the most meaningful path towards creating efficient drug markets that protect the public health.[35,3]

Historically, legal guidance on complex and controversial issues such as decriminalization have been guided by the independent Law Commission of Canada (LCC), which was defunded by the federal government in 2006 despite having a strong track record of providing a number of key recommendations on highly salient social policy issues affecting key populations such as GBQM (e.g., In 2004, the LCC recommended revoking prohibitions against same-sex marriage).

Recommendations

With consideration to the prioritized legal and policy options outlined above, we recommend:

(1) Revising the *Canadian Drugs and Substances Strategy* to include commitments to supporting substance use programming tailored for GBQM and other sexual and gender minorities. These revisions should:

a. list GBQM and other sexual and gender minorities as a priority population for prevention, treatment, and harm reduction;
b. prioritize funding for prevention, harm reduction, and treatment over enforcement;
c. create and fund a separate track within Health Canada's Substance Use and Addictions Program (SUAP) for grant application proposals addressing sexual and gender minority's substance use;
d. provide funding through the Canadian Institutes of Health Research to establish a network of treatment services aimed at delivering, comparing, and evaluating substance use programming (e.g., treatment, harm reduction) for GBQM and other sexual and gender minorities;
e. provide more resources through the Public Health Agency of Canada for harm reduction supplies and educational materials related to substance use within the context of intimate sexual encounters to address the unique intersection of mental health and sexual health needs of these communities;
f. make GBQM and other sexual and gender minorities a priority population for mental health calls for proposals by the Public Health Agency of Canada to address underlying realities often associated with substance use among our communities (e.g. trauma, depression, loneliness, body image issues);
g. adopt an intersectional and holistic approach to sexual and gender minority health and wellness that accounts for key overlapping identities and experiences (e.g., Two-Spirit and other Indigenous GBQM, racialized GBQM); and
h. provide funding through the Public Health Agency of Canada for enhanced, community-led surveillance that focuses on the structural factors that impact access to mental health and substance use care for GBQM and other sexual and gender minorities;

(2) Establishing a Law Commission of Canada (LCC) to provide independent advice on improvements, modernization, and reform of the *Criminal Code* and *Controlled Drugs and Substances Act*. This LCC should:

a. consist of at least 5 commissioners, representing expertise in sexual health, addictions treatment, harm reduction, and sexual and gender minority wellness;
b. be appointed by the Cabinet at the recommendation of the Minister of Health;
c. exemplify a multidisciplinary approach and engage a broad range of stakeholders and communities, including sexual minorities who use drugs;
d. adopt a rights-based approach that follows the CDSS's guiding principles (i.e., comprehensive, collaborative, compassionate, and evidence based);
e. provide legislative guidance to key parliamentary officers and committees through reports on methodologies and strategies to reduce substance use related harms and risks arising from drug supply contamination.

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