

# HIV and recreational drug use: what nurses need to know

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## Abstract

Since the beginning of the HIV epidemic the role, effect and influence of recreational psychoactive drug use is undeniable. It has played a factor in HIV transmission and has had an effect upon adherence and interactions with antiretroviral therapy (ART). Across the globe the HIV epidemic has consisted of pockets of prevalence within certain at-risk groups; in the UK, particularly Scotland, recreational drug use was predominantly in the drug injecting population. In London agencies had been set up to specifically support recreational drug users living with HIV such as the (now closed) 'Griffin Project' in Earls Court and 'Mainliners'. However, the introduction of ART and the reduction in mortality in people living with HIV along with the improved tolerability of newer drugs have led to HIV being considered a chronic condition. At the beginning of the epidemic little time was spent looking at the long-term effects of diet, smoking, alcohol and drug consumption, but today with a near normal life expectancy there is a need for an approach that is tailored to individual needs. This means addressing concerns such as the management of comorbidities, linkage to care and issues such as smoking cessation, alcohol reduction and recreational drug consumption.

**Keywords:** HIV, recreational drugs, chemsex, drug interactions, ART

## A. Revalidation

This article has been prepared with continuing professional development (CPD) in mind and can be used to support your revalidation. It is estimated that 2.5 hours of CPD activity will be required for completion of the reading, 'time out' activities, the quiz and writing a brief reflective account in relation to your learning and its applicability to your practice. There is a self-assessment quiz at the end of this article for you to assess what you have learnt.

## B. Aims and intended learning outcomes

The article aims to increase your knowledge about recreational drug use and the effect this has upon someone living with HIV.

After reading this article, undertaking the activities and completing the self-assessment quiz you should be able to:

- understand and define the different classes of recreational drugs;
- list and discuss the effects different kinds of recreational drugs can have on people;
- show awareness of your own role in supporting people living with HIV and recreational drug use;
- describe the ways certain recreational drugs interact with antiretroviral medication; and
- review your current practice and guidelines around management of people living with HIV who have issues with recreational drug use including chemsex.

## C. Introduction

Recreational drugs and their role in people acquiring HIV and the resultant effects upon ART and adherence have been concerns for healthcare professionals working in HIV for a decade. Recreational drug use and addiction have been linked since the beginning of the HIV epidemic, with the commonest substances used in the early days, 'street drugs', such as heroin and crack cocaine [1]. The effects of sharing injecting equipment saw a rise of HIV transmission among those who injected, commonly called intravenous drug users (IVDUs), a term no longer used. Further studies have shown that people living with HIV are more likely to use alcohol and recreational drugs such as marijuana, cocaine and other stimulants [2], with high rates of benzodiazepine use [3]. The prevalence of tobacco smoking among people with HIV is higher than in the general population [4]. Over the past few decades different recreational drugs have become more frequently used among men who have sex with men (MSM) especially those living with HIV [5,6]. These 'party' or 'club drugs' are often used for sex and taken in clubs or house parties, which can last for entire weekends [7,8].

Drug use, especially for MSM and the risk of HIV transmission is a well-researched area [5,9], particularly the use of 'chemsex' drugs such as crystal meth, gamma hydroxybutyrate (GBH) and mephedrone [10–12]. Chemsex drugs such as methamphetamine, gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL) and mephedrone have been associated with increased

sexual risk behaviours that may lead to an increase in sexually transmitted infections. These drugs can also increase disinhibition and hypersexuality, leading to unwanted sexual experiences and can induce coma, with reports of use associated with sexual assault [13]. Continued use can induce agitation, anxiety, paranoia, aggression and psychoses. Intense comedowns can cause users to feel suicidal and there are reports of overdose with unconsciousness and death [14]. A high prevalence of polydrug use and chemsex drug use among MSM without HIV attending UK sexual health clinics has recently been shown, and recreational drug use was strongly associated with sexual behaviours linked to risk of acquisition of STIs and HIV [15]. A study by Garin *et al.* in 2015 concluded that a high proportion of individuals with HIV consume new recreational drugs (ketamine, GHB, mephedrone) and drugs associated with specific sexual behaviours, such as erection enhancement medication and poppers [16]. We know that smoking, alcohol use and recreational drug use contribute to cardiovascular disease development, ranging from subclinical atherosclerosis to fatal acute coronary syndromes [17–19]. Increased risk for cardiovascular disease (CVD) already exists among people living with HIV [20], and people living with HIV who smoke have been estimated to carry twice the risk of a major cardiovascular event compared to non-smokers with HIV [21].

#### Time out activity 1

Make a list of addictive substances, not just recreational drugs, that patients have mentioned, or you are aware of. List them along with their common names and categorise them into legal or illegal drugs.

Now look at the Talk to Frank ([www.talktofrank.com/drugs-a-z](http://www.talktofrank.com/drugs-a-z)) website, a great resource, for other drugs.

## D. Defining recreational drugs

Psychoactive drugs have been around since the dawn of man and have fallen in and out of fashion. They have been used by priests in religious ceremonies to induce states of dissociative trances, such as the use of the mushroom *Amanita muscaria*; 'healers' have used drugs, such as opium, for medical reasons, which has been described in some of the earliest written records from 9th Century BC and in *Homer's Odyssey*, where Homer writes that Helen of Troy treated wounded Greek warriors: '*... presently she cast a drug into the wine of which they drank to lull all pain and anger and bring forgetfulness of every sorrow*'. Drugs have been used in the general 'normal' population in a socially, legal 'licit', approved way such as alcohol, nicotine, and caffeine, whereas harder, illegal/illicit, drugs are seen as being used by 'deviants' [22]. The effects of alcohol are noted throughout history, for example by the Greeks in 323 BC, where Aristotle noted the effects of alcohol withdrawal and warned against alcohol use in pregnancy, and the Roman physician, Celsus, who noted that dependence on alcohol was a disease. In *Macbeth*, William Shakespeare wrote that alcohol '*provokes the desire, but it takes*

*away the performance,*' and in *Othello*: '*O thou invisible spirit of wine, if thou hast no name to be known by, let us call thee devil.*'

For MSM the role of alcohol and recreational drugs have been used sexually to '*provide the incentive, licence and fortitude to act on same-sex desires that have been severely socially stigmatised historically*' [23], and in the MSM community the pattern of drug use can be seen from the disco era in the 1970s through to the rave culture of the 1990s, and more recently chemsex, which has bonded some of the MSM in a community and subculture [24–26].

Most psychoactive drugs affect the brain's 'reward centre', causing euphoria as well as flooding it with dopamine. A properly functioning reward system motivates a person to repeat behaviours needed to thrive, such as eating and socialising. However, surges of dopamine in the reward centre cause the reinforcement of pleasurable but unhealthy behaviours like taking recreational drugs leading people to repeat the behaviour again and again. As a person continues to use drugs, the brain adapts by reducing the ability of cells in the reward centre to respond to it. This reduces the later high the person feels compared to the high they felt when first taking the drug, this is known as tolerance, therefore, they might take more of the drug to try and achieve the same initial high. These brain adaptations often lead to the person becoming less and less able to derive pleasure from other things they once enjoyed, like food, sex or social activities.

People use recreational drugs for a number of reasons that can be summed in the following five points:

1. **Experimental use** – drug use is motivated by curiosity or desire to experience new feelings or moods. This may occur in solitude or in the company of one or more friends who are also experimenting. It normally involves single or short-term use.
2. **Social/recreational use** – drugs are used on specific social occasions by experienced users who know what drug suits them and in what circumstances (e.g. ecstasy use by experienced users at dance parties, or alcohol with a meal).
3. **Circumstantial/situational use** – drugs are used when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought (e.g. truck driving, shift work or studying for exams).
4. **Intensive use** – this drug use is similar to the previous category, but more intensive. It is often related to an individual's need to achieve relief or to achieve a high level of performance. It can also involve binge use, where there is excessive use of a substance at one time. The pattern of binge use may be occasional, or may relate to specific situations.
5. **Compulsive/dependent use** – drug use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress. Drug use is central to the user's day-to-day life.

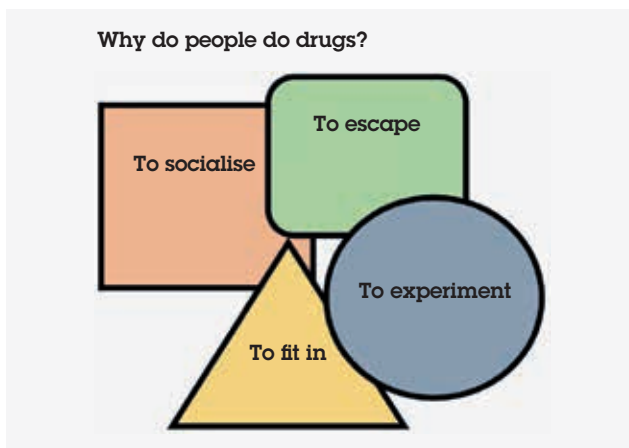


Figure 1: Some reasons for drug use

Schaeffer's model acknowledges that most people use drugs in an experimental or recreational manner, see Figure 1 [27]. This is particularly true for young people, who often experiment with various substances as part of growing up. Drug use by recreational users serves different purposes than drug use by intensive and particularly compulsive users. In other words, recreational users and intensive or compulsive users use drugs for different reasons. To sum this up **recreational drug users** tend to use drugs to have 'fun' or 'party' and this use is more about curiosity, rebellion, being social, relaxing, confidence building and the physical sensations of the drug; whereas **intensive and particularly compulsive drug use** is more motivated by deeper psychological processes, such as self-medication and providing relief from negative emotions. This second type of drug use is about reducing a sense of alienation, identity formation, self-medication, relieving emotional distress and improving self-regulation (soothing your emotions).

## E. Types of recreational drugs and their effects

There are numerous psychoactive drugs or drugs of addiction that could be discussed in this article, however, for ease I have chosen ones that are common and/or interact with ART. The role of alcohol and nicotine are discussed briefly but are complex and require a separate article. For the present, I shall categorise all 'street', 'party', 'illegal/illicit', 'chemsex' drugs as recreational drugs. There are five categories of recreational drugs:

**Stimulant** drugs that make you feel alert, energetic, active and talkative. They are addictive and can cause psychosis and paranoia. Examples are anabolic steroids, amphetamines and methamphetamines, cocaine, crack cocaine, uppers and mephedrone (M-CAT).

**Depressant** drugs that make you feel relaxed, mellow and chilled, although can cause anxiety and aggression. They are addictive and can be dangerous at high doses. Examples are benzodiazepines (tranquilisers, downers).

**Opium-related analgesia** can cause a rush of pleasure, dreamy feelings and drowsiness. Again, they are dangerous at high doses and are addictive. Examples are buprenorphine.

**Hallucinogens**, the effects of which can vary. They can make you feel detached with an altered sense of space and time, give you hallucinations and a distortion of reality, and mood swings.

**New psychoactive substances** used to be called 'legal highs' but all are now illegal. They are synthetic drugs created to try to mimic the effects of existing stimulant, depressant and hallucinogenic drugs to get around the law. Most have unknown effects in addition to their intended effect and trying them is, therefore, extremely hazardous. They are sold as powders, pills, smoking mixtures, liquids, capsules or on perforated tabs, an example is Spice (black mamba, Mary joy).

Drugs like cannabis can fit into many categories depending upon how they are taken (marijuana, hemp, hashish, skunk) and the form in which they are taken. Box 1. gives a summary of some common drugs, how they are taken and their effects.

### Time out activity 2

How do you discuss drug use with patients? What discussions do you have around living with HIV and recreational drug use, do you highlight potential drug interactions, if so what are your main concerns?

## F. Effect of recreational drugs on HIV treatment

In order to think about the way recreational drugs effect ART we need to look briefly at how the body metabolises drugs. Cytochrome P450 (CYP) enzymes are essential for the metabolism of many medications. Although this class has more than 50 enzymes, six of them metabolise 90% of drugs, they also are necessary for the detoxification of foreign chemicals and the metabolism of drugs [28]. These CYP enzymes are predominantly expressed in the liver, but they also occur in the small intestine (reducing drug bioavailability), lungs, placenta and kidneys [29]. Many drug interactions are the result of an alteration of CYP450 metabolism [30].

There are two main areas of concern with recreational drug use, the first is its effect upon the individual taking risk, whether that be sharing injecting equipment or lowering sexual inhibitions; making a person more 'at risk' of acquiring not only HIV but other sexually transmitted infections. The second concern is the interaction between ART and the recreational drug, and its effect upon adherence. The effect that some recreational drugs can have upon ART are updated and documented well, see the [www.hiv-druginteractions.org](http://www.hiv-druginteractions.org) [31]. There are some considerations here and having an honest discussion with the person living with HIV and making an assessment around this is important so that they are aware of potential issues. Bracchi

**Box 1. Summary of common drugs: class and effects**

Name of drug, intake method, class and addiction	Type of drug	Short-term effect	Long-term effect
<ul style="list-style-type: none"> <li>Amphetamine</li> <li>Methamphetamine (crystal meth)</li> </ul> Class A – illegal to sell or possess Physical and psychological dependence	Stimulant	Increased attention and alertness Reduced tiredness Increased energy and confidence	Agitation Confusion Aggression Psychosis; paranoia
<ul style="list-style-type: none"> <li>Gamma hydroxybutyrate (GHB and GBL)</li> </ul> Usually swallowed but certain forms can be snorted or injected (GBL) Class C – illegal to sell or possess Physical dependence	Depressant	Loss of inhibitions Calmness Sedation Confusion	Effects can last up to 7 hours
<ul style="list-style-type: none"> <li>Ketamine (special K)</li> </ul> Ingested, snorted or injected Class B – illegal to sell or possess Psychological dependence	Hallucinogenic	Poor concentration. Changed perception of surroundings – things not ‘looking right’ or ‘feeling right’. Feeling out of touch with reality and surroundings. Delusions Paranoia Dream-like states Nightmares Feeling you have no thoughts. A ‘bad trip’ may make you violent, suicidal or likely to harm yourself.	Difficulty thinking clearly Depression Panic attacks Anxiety
<ul style="list-style-type: none"> <li>Mephedrone (meow, meow)</li> </ul> Snorted, ingested or injected Class B – illegal to sell or possess Psychological/compulsive dependence	Stimulant	Alertness, confidence Talkativeness Agitation Anxiety Hallucinations (hearing and seeing things, and strange touch sensations). Paranoid delusions (even if taking antipsychotic medication). Depression Suicidal feelings	No long-term effect
<ul style="list-style-type: none"> <li>Cannabis smoked, ingested</li> </ul> Class B – illegal to sell or possess in large amounts but is subject to discretionary warnings for small amounts. Physical dependence	Stimulant, depressant and hallucinogen	Feeling relaxed Talkative Finding things very funny and laughing a lot. Feeling excited by the things you see, hear and feel. Hunger High doses may cause: distorted perceptions, forgetfulness, distress and confusion. Psychotic experiences (hallucinations or other unshared perceptions)	Long-lasting symptoms of psychosis, which may be diagnosed as schizophrenia. Depression in later life, if used a lot as a teenager.

**Box 1. Summary of common drugs: class and effects (continued)**

Name of drug, intake method, class and addiction	Type of drug	Short-term effect	Long-term effect
<ul style="list-style-type: none"> <li>▪ Cocaine – snorted</li> <li>▪ Crack cocaine – smoked</li> </ul> Class A – illegal to sell or possess Psychological dependence	Stimulant	Feeling wide awake Full of energy Feeling confident High doses may cause: hallucinations and delusions, depression and suicidal thoughts.	Depression Anxiety Panic attacks Paranoia Irreversible brain damage. Worsening of pre-existing mental health problems. Repetitive movements
<ul style="list-style-type: none"> <li>▪ Ecstasy (MDMA)</li> </ul> Ingested as pills or powder Class A – illegal to have for yourself, give away or sell. Psychological dependence	Stimulant	Feeling happy and relaxed. Feelings of empathy, openness and caring.	Depression, which does not respond to antidepressants. Loss of confidence Anxiety Confusion Agitation and teeth clenching. Panic attacks after repeated use. Hallucinations and paranoia after repeated high doses.

et al., in 2015, set this out clearly looking at the interactions and potential issues, stating that drug interactions occur through various mechanisms, which include inhibition or induction of specific enzymes and proteins [32]. The way in which the drug is taken can also enhance or slow down the effect, such as intravenous injection (also known as slamming) that can maximise the bioavailability of the substance, followed by insertion in the rectum, with oral ingestion leading to more extensive first metabolism; other common ways of intake can be through nasal insufflation (snorting) or smoking. With induction of a metabolic pathway lower drug concentrations are obtained and potentially a lack of desired effect. This may start a vicious circle, in which the individuals combine more substances or increase their doses, with even greater and more unpredictable risks of toxicity. Lower drug effects consequent to induced metabolism may also theoretically lead to individuals injecting to avoid first-pass metabolism rather than continue oral intake. Any subsequent switch in antiretroviral regimen could potentially trigger acute intoxication, as these interactions usually pass unrecognised. Drug interactions can also be of a pharmacodynamic nature, and severe organ-related toxicity may be exacerbated by some antiretrovirals. There is low potential for interaction between antiretrovirals and alcohol, cannabis, opioids and nitrates.

Most recreational drug/ART interaction issues appear to be with the use of boosted protease inhibitors (with ritonavir or cobicistat), which can have an effect on methadone use, subsequently requiring an increase in methadone dose to accommodate this. Recreation drug-ART interaction may appear with the use of erectile dysfunction agents, such as Viagra, sildenafil, Cialis. Interactions are likely to occur frequently since medicines and most recreational drugs share the

CYP450 metabolic pathway, adherence may be decreased, and high-risk sexual behaviour increases [7]. Protease inhibitors are known to interact with cocaine through the CYP3A pathway resulting in an increased risk of cocaine toxicity [33]. Benzodiazepines (midazolam and triazolam) is another recreational drug group to highlight. Problems with adherence to ART were twice as high in methamphetamine users compared with non-users [34].

**Time out activity 3**

What services do you have in your area to support people with issues around their drug use (list all drug and alcohol agencies)? Do a quick internet search to see what is in your locale. Do your colleagues know what is available?

**G. How do we assess and manage patients who use recreational drugs?**

Stuart and Weymann offer the following as a list of suggested questions, their article discusses care planning for chemsex but can be easily adapted for all recreational drug use [35]:

- 'Do you use party drugs for sex?'
- 'What's your preferred drug?'
- 'When did you last have sober sex?'
- 'How long do you stay awake for?'
- 'Do you sometimes regret the choices you make when you're high?'
- 'Have you had any bad experiences on the second or third day awake?' (e.g. paranoia)
- 'Would you like to speak with a health advisor about taking a break from chems?'

It's worth noting that MSM who use recreational drugs, particularly chemsex, may not see themselves as 'typical' drug misusers or consider the use of chemsex

drugs to be problematic and are therefore unlikely to access traditional drug services [36], traditional drug and alcohol services may not be trained to deal with the specific needs of this population [37].

When a patient does consent to a discussion about their recreational drug use behaviour, the nurse can encounter defensiveness, denial, ambivalence or fear about making changes. As mentioned Stuart and Weymann, in 2015, devised a care plan for chemsex use but the principles for other recreational drug use remain [35], which includes the following:

### Identifying a goal to achieve

A good starting point is to set small achievable goals. A simple step may be to ask them how confident they are that they can achieve the set goal, such as the steps employed in self-management programmes with a confidence of 7 or more (out of 10) needed to succeed. Stating that they want to stop their drug use forever may be too high a goal (this may be the ultimate aim, but how are they going to get there?) and perhaps smaller steps would be to have a drug/chem free weekend, week or month. A small step may be just attending a club-drug clinic, making a self-referral or finding out where a local narcotics/chemsex/alcoholics anonymous meeting is. Setting unrealistic goals can lead to failure, and failed goals can demotivate a person risking disengagement from services owing to embarrassment or shame about failing to achieve.

### Identifying circumstances/situations likely to cause a craving or lapse in behaviour

This can include compulsive use of sexual networking apps/sites, being bored/unoccupied, invitations from sex-buddies, attempts to have sober sex, drinking alcohol, clubbing or certain times of the day/week.

### Tips for managing triggers and cravings

The following tips can help: not making impulsive decisions; changing one's emotional state by getting out of the house or calling a supportive friend; distracting oneself from the craving by other means/hobbies; and having a full diary of things to do, preferably with friends.

## H. Management of recreational drug use and HIV

As general nurses, managing recreational drug use and people who identify with an addiction may not be something we come across on a daily basis and the need to 'fix' the problem may be strong and therefore a challenge. Stuart suggests a golden rule that people attending our services may not be seeking any support around their drug use [38]. The following are a few points that you may find useful:

### Signposting

You may or may not be the expert. Get to know services and specialists in your local area, it may be useful to draw up a resource list so that people who use

recreational drugs and who want support to stop, or advice in harm reduction, can decide who is best to support them, especially if they do not identify as having a problem and may find accessing drug and alcohol services challenging. 56 Dean Street's 'Wellness Programme' ([community.dean.st](http://community.dean.st)) offers information on other ways to meet people away from the drugs scene that can be useful if someone is stuck in a particular scene. Club-drug clinics ([clubdrugclinic.cnl.nhs.uk/](http://clubdrugclinic.cnl.nhs.uk/)) are being developed in larger cities and will offer more structured help. Highlight clinics you have 'in-house' that may be useful as starting points, don't assume that everyone reads the noticeboards and information in reception.

### Communication

We should always be sensitive and non-judgemental in our work, however there are some issues that will elicit a concern or moralistic judgment, such as decisions people may make around their religious beliefs, for example the use of blood for a Jehovah's Witness; the kind and frequency of sex people have (whether we believe this to be reckless, dangerous or irresponsible); the amount of alcohol people consume and the amount and type of recreational drugs people take amongst others. Recreational drug use is an issue where we may inadvertently display our own experience, moralistic values or stereotypes. How many times have you thought or said. '*They don't look like a drug user,*' or made assumptions about how they present themselves: '*They inject heroin therefore they are chaotic, irrational, won't tell the truth,*' '*Whatever they say they drink I double it.*' How you ask about a person's recreational drug use can either encourage or deter them from being open and honest with you. '*What kind of recreational drugs do you take?*' may get a better response than '*Do you take recreational drugs?*' which could get a decisive 'yes' or 'no' answer, depending upon whether they feel they can speak to you or not. The language we use is important so avoid words like 'illicit/illegal', 'addict/addiction', 'drug misuse/abuse'. If the patient tells you about their drug use then explore what they take and how. Having an awareness of how drugs are taken is, therefore, important so that you don't make assumptions: they take methamphetamine so they must inject therefore we'll discuss slamming, and listening to concerns and supporting someone with harm reduction information may be something you can offer rather than advise on stopping, unless this is what they requested. Many organisations have a proforma that may well phrase this question for you.

### Nurses need to solve a problem

As nurses we are practical and great 'doers' and in some situations there's little we can do. Not everyone who takes recreational drugs has or feels they have a problem despite what they may show or tell you. This can be a huge challenge for everyone in health care as all we can do at this time is to raise our concerns and offer support, but we may well have to wait until

the person is ready for help. Reflecting what you observe back to the person can be a strong motivator, you could ask: *'I'm concerned because you look like you have lost a lot of weight'* or *'I'm worried as you seem to be quite paranoid/distracted at the moment,'* but forcing the issue could mean that the patient will disengage from care all together. A patient of mine once left a clinic as the doctor advised him that she was concerned about his heart and wanted a cardiologist to see him, but he knew she was alerting the drugs team as *'she didn't even check my pulse or listen to my heart'*. When the doctor was questioned some days later this is exactly what she had been doing but felt the patient was too distracted to notice. Having literature, websites or other resources readily available to signpost organisations that can help 'in case you feel it is becoming problematic' is helpful.

### Problem solve with the patient

I once had a patient who missed ART doses because when he took methamphetamine he forgot, so we looked at when and where he took the meth, which was at his computer after work. We looked at signage (don't forget your pills, with an arrow pointed at his ART) or taping the messages to his computer screen (this worked the best). Voice your concerns and see if you can work around them, providing key-ring pill holders can be a simple measure to ensure they have a day or two's supply with them.

### Whose responsibility is it anyway?

This can be difficult if the patient doesn't identify as having problematic drug use, despite the way they may look or present themselves. Asking for help may be difficult and we often have people presenting as delusional, psychotic or paranoid and the first thought may well be to refer for mental health support; however the patient may not be able to access mental health support as the service will see the issue as relating to the patient's recreational drug use. Similarly, if a patient doesn't identify as needing the support from a designated drug service, it may well be left to their GP or HIV services to manage them until they actively seek referral to a drug support agency. Some clinics may have access to a club-drug clinic or a 12 step programme such as local Alcohol/Narcotic or Chem sex Anonymous. Being open, flexible with clinic timings and having the time and resources to support someone through this period is important, as are having boundaries in place to not treat people who are obviously intoxicated at appointments.

### Learn the art of walking away

Listen to what the patient is telling you and react appropriately in a non-judgemental way. If they say they don't have a problem, that they don't need help, then advise that we/you are here as an when needed. As Stuart neatly sums up:

*'... if [a drug user] remembers a caring, informed and non-judgmental consultation with your clinic, [they] will be highly likely to seek support from you when that time comes.'* [38]

### Time out activity 4

What policies do you have to support yourself for the management of people who take recreational drugs, especially if they come to clinic clearly intoxicated or 'high'?

## I. Conclusion

There are many considerations when discussing recreational drug use with people living with HIV. Getting an open, honest and clear picture of present and potential recreational drug use is important, as is ensuring that the patient is made aware of potential drug–drug interactions. However, as more synthetic recreational drugs come onto the scene and the development of new ART we have to respond to an ever-changing market. The University of Liverpool's interactions website is a great resource [31], being alert to potential drug–drug interactions and having a non-boosted ART regimen may be a useful start. Bracchi *et al.* suggest that nucleoside reverse-transcriptase inhibitors (NRTIs), rilpivirine, raltegravir, dolutegravir and maraviroc are all ART agents with a low potential for interaction with 'party drugs', they may be preferred in patients who use illicit drugs to avoid additional toxicity [32]. Getting to know your local support services, knowing when to take a step back from the conversation and offering advice when needed to the person in front of you, rather than from your own need to resolve the situation is a key skill to possess.

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