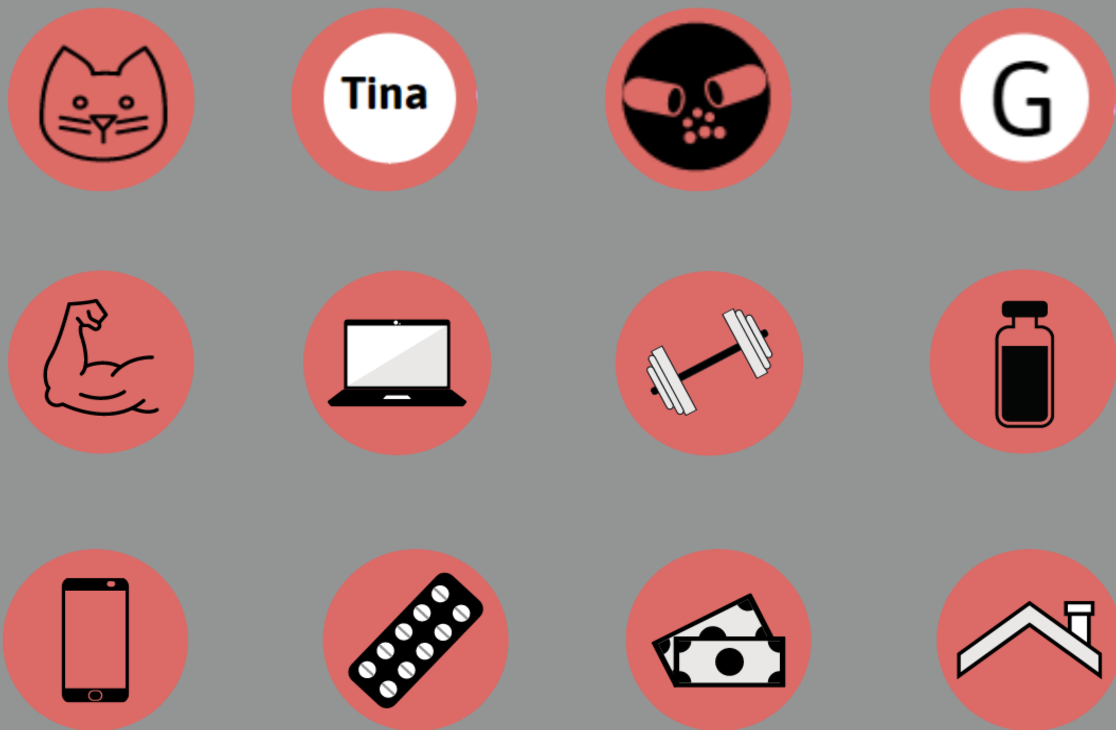
SDF Scottish Drugs Forum

Understanding the Sexual Health and Blood Borne Virus Risk Behaviours of Defined 'at risk' Groups to Inform a Service Training Programme



Scottish Drugs Forum

May 2020

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Definitions and Abbreviations

Abbreviations Used

SDF: Scottish Drugs Forum
BBV: Blood Borne Virus
IPEDs: Image and Performance Enhancing Drugs
GGC: Greater Glasgow and Clyde
GHB: gamma hydroxybutyrate
GBL: gamma butyrolactone
(Amongst MSM, the term G is used to refer to both GHB and GBL)
MSM: men who have sex with men
Chems: alternative term used by MSM for drugs
PrEP: Pre exposure prophylaxis (for HIV)
PCT: Post Cycle Therapy

Definitions

Chemsex: the use of any combination of drugs that may include crystal methamphetamine, mephedrone, and/or GHB/GBL by MSM before or during sex

Slamming: injecting of drugs, generally crystal methamphetamine and/or mephedrone, by MSM before or during sex

Transactional Sex: an all-encompassing term to include prostitution and sex work

Preamble and Thanks

Scottish Drugs Forum (SDF) has had a specific role in the sexual and reproductive health (S&RH) of people who use drugs since 2012 when the organisation was awarded funding through the Scottish Government's Sexual Health and Blood Borne Virus Framework. Throughout this time workers have focussed on delivering training on S&RH to staff working in drug services and training on drug issues to staff working in sexual health services.

In recent years three areas of work, where drugs and S&RH are linked with a range of health and social harms, have come to the fore. These are: what has become to be known as chemsex; transactional sex; and the use of image and performance enhancing drugs (IPEDs).

In order to better meet the needs of service users involved in these activities, primarily to ensure reduction of harms in relation to drug use, sexual health and stigma, SDF sought funding to carry out research both with drug users themselves and with the staff supporting them. This report details the information gathered and highlights key issues around drugs used and sexual health issues, related harms and consequences, and information needs. It also gives recommendations with regards to the type of training which should be available for staff who support people involved in chemsex, transactional sex and IPED use.

SDF would particularly like to thank the following services and their service users for all their help and support in carrying out the research:

Fife

- Sexual Health Fife: BBV Clinics
- Addaction
- Clued Up

Grampian

- Turning Point Scotland
- Grampian MCN
- Four Pillars
- Alcohol and Drugs Action
- Cyrenians
- Sexual Health Grampian
- Arrows - Quarriers

Greater Glasgow and Clyde

- Sexual Health Services - Sandyford
- Glasgow IPED Clinic - West Street
- Turning Point Scotland
- Routes Out

Lothian

- Chalmers Sexual Health Centre
- ROAM Outreach
- Spittal Street Centre
- Turning Point Scotland
- Crew 2000
- Sacro – Another way

Scotland - Wide

- Waverley Care including SX
- Terrence Higgins Trust
- Women's Support Project

Finally, while this research was carried out pre COVID – 19, the recommendations would remain the same, but the style of training delivery will require further development for on-line and virtual learning.

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Introduction

Background

Scottish Drugs Forum was awarded Scottish Government funding to conduct baseline research with particular at-risk populations and frontline services to identify specific risks in terms of drug use and sexual health, treatment needs, information needs and what workers need to know in order to support these populations effectively. This would inform the development of information and training resources and programmes, ensuring that the workforce and service providers working with the three target groups are fully trained and equipped to support service users with their sexual health, blood borne viruses and harm reduction needs. The at-risk populations were:

1. MSM involved in Chemsex,
2. People who use image and performance enhancing drugs (IPEDs),
3. People (men and women) involved in transactional sex who use drugs.

It is key that these different populations have their individual risk behaviours and information needs understood and addressed rather than applying universal prevention/harm reduction approaches used when addressing substance use issues. Equally it is important that services are fully equipped, skilled and confident when responding to these target groups and engaging them in prevention/harm reduction.

Chemsex has been a growing and emerging trend within the MSM population over the last 5-10 years. Chemsex involves the use of psychoactive drugs, commonly referred to as "chems". Mephedrone, gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL) and methamphetamine are the most commonly used substances (Bourne et al, 2014). Some of these men inject the drugs intravenously, which they refer to as 'slamming'. Chems are often used during sexual activity to enhance pleasure and reduce inhibitions. This can result in increased risk taking around sex and drug use, including condomless sex, which can lead to higher rates of STIs and BBVs (Ottaway, Finnerty, Amlani et al., 2017; Page & Nelson, 2016). According to the Scottish Government BBV framework, young people and MSM are identified as being the highest at-risk groups for STI transmission and MSM and people who inject drugs have the highest risk of HIV in Scotland (Scottish Government, 2015).

Recent IPEDs research has identified that people who use IPEDs report a broad range of illicit and prescription drugs taken alongside IPEDs which present a variety of possible health risks and may impact on additional risk-taking behaviours. The uptake of BBV testing and vaccination by people who use IPEDs is reported as low, although reasons for this are unclear. (Begley et al, 2017) Previous research with people who use IPEDs found they relied on other IPED users for information about drugs, which was often inaccurate. They also often had their drugs injected by other IPED users (Santos & Coomber, 2017). Some risk behaviours have already been identified such as using small narrow bore needles that can break off in muscle tissue (Dunn et al, 2014). Furthermore, in the UK tensions have been identified between service providers and IPED users as a result of different perspectives of potential risk behaviours and interventions (Kimergard & McVeigh, 2014). In addition to injecting risk taking, in terms of sexual health, people who use IPEDs often report high rates of sexual activity but low levels of condom use which would suggest a significant risk factor for STIs and BBVs (Begley et al, 2017).

People involved in transactional sex who use drugs may experience a range of challenges including stigma, exploitation and trauma which have an impact on risk taking behaviours relating to drug use and sex. These challenges may affect engagement with support services. There is evidence globally that sexual health services may focus on MSM and the general population whilst vulnerable female groups such as those involved in transactional sex are under-provided for (Pinkham & Sepruch, 2008). There are known risks for people involved in transactional sex such as the transmission of sexually transmitted infections, risks associated with injecting drug use (BBV, injection injury, overdose etc), and violence (Spice, 2007). However it is surprising how little research has been conducted recently which is specific to the Scottish population and considers changes in drug use (e.g. new psychoactive substances) as well as the rise in drug related deaths in women (Tweed et al, 2018).

As part of the funding agreement SDF, working with an experienced health service researcher (Co-I, CM), undertook research across Scotland with each of these groups, to inform the content of a training programme for staff working with these populations. Although these three groups are quite distinct the information being sought, and the purpose of seeking that information is the same. This report describes the data collection and findings of interviews with each target group as well as focus groups with service providers. It then identifies key issues for training and service development.

Aim and Objectives

This research aimed to identify information, support and treatment needs associated with drug use, sexual health and BBV risk taking behaviours of three defined target groups (Chemsex/IPEDs/ transactional sex) and associated support service staff.

To deliver this aim the following specific objective were to:
1. describe the risk-taking behaviours in relation to drug taking, sexual health and transmission of BBV of the three target groups.
2. identify the information, treatment and support needs of the three target groups.
3. identify the training needs in terms of content and format, for workers in support services.
4. inform the development of a training programme for service providers on sexual health and BBV for the three defined groups.

This can also be articulated by these research questions
In terms of sexual health, blood borne viruses and drug use of the three populations:
1. What are the specific risk-taking behaviours?
2. What are the information, treatment and support needs?
3. What should be included in training for workers in support services?

This report covers one and two, above; the training programme has been developed based on the findings of this research.

Methods

A qualitative methodology was applied via face-to-face and telephone semi structured interviews with participants in each target group. Qualitative focus groups were held with service providers. The research team developed the materials (topic guides, posters and fliers) in consultation with advisors who were consulted for their expertise as required. This included people from target groups and staff in the sector with specialist expertise.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria for interview participation are listed below.

Inclusion criteria:
1. MSM engaging in chemsex
2. People who use IPEDS for the purpose of enhancing physical appearance, strength or conditioning
3. People (women or men) involved in transactional sex who use drugs
4. All participants must be 18 years or over
5. Able to provide informed consent
6. Live in Scotland

Exclusion criteria:
1. Men who only use sildenafil (Viagra)
2. Athletes who use drugs to enhance competitive sport performance
3. People who use cognitive enhancers only

Service providers inclusion criteria:
Those working in services that serve any or all of the three target groups and come into contact with any or all of the three target groups in their professional role including:
1. Sexual health clinics
2. Injecting equipment providers (IEPs) that specialise in IPEDs
3. Outreach services for those involved in transactional sex

Recruitment

Four health board areas participated: Greater Glasgow and Clyde (GGC), Lothian, Fife and Grampian. Sexual and reproductive health clinics, injecting equipment providers (IEPs) who distribute equipment and paraphernalia in relation to IPED use, and services that specialise in IPEDs or transactional sex in each area were asked to display posters and host a researcher on a set day/days to be available for interviews on site.

Face to face interviews

Those meeting the inclusion criteria were given a participant information leaflet by the service staff or forwarded by the researcher if from an independent enquiry. They were told that the researcher-

would be present in the service on a specific day(s) over the next month to undertake interviews. Those expressing an interest were given an appointment date and time. Flexibility was important and researchers were available to undertake interviews at short notice if possible, and if requested by participants.

Telephone interviews

Posters, cards and fliers were displayed and distributed widely through services and in clubs, bars and gyms. Posters, cards and fliers gave a phone with a telephone number to make contact by call, text or whatsapp. A web site was also provided that linked to more information on the study. Social media was also used to raise awareness.

Interview Content

Interviews were conducted by trained data collectors used a semi-structured topic guide developed by the SDF team and Advisory Group and informed by the literature. Topics covered were:

Chemsex:
- First experiences of chemsex (setting, who with, drugs used and route of administration and frequency of use)
- Patterns of drug use in relation to sexual activity
- Who are you having sex with? Is it the same people? Where do you meet them/contact them? Typical episode?
- Sexual risk taking e.g. unprotected sex
- Last sexual health check-up?
- Use of pre and post exposure HIV prophylaxis
- Sources of information on drugs (have you looked for information? Where and what did you find?)
- Have you every sought support or treatment as a consequence of involvement in chemsex (what? who? where and why?)
- Experiences of support or treatment around drug use and/or sexual health services e.g. screening or advice

IPEDs:
- First experiences of IPED use (setting, who with, drugs used and route of administration and frequency of use)
- Sexual activity
- Sources of information on drugs (have you looked for information? Where and what did you find?)
- Have you every sought support or treatment for your drug use (what? who? where and why?)
- Experiences of support or treatment around drug use and/or sexual health services e.g. screening or advice
- What do you need from services?

Transactional sex:

- First experiences of drug use (setting, who with, drugs used and route of administration and frequency of use)
- First experience of transactional sex – why, where, who?
- Frequency and type of transactional sex
- Sources of information on drugs (have you looked for information? where and what did you find? was it useful?)
- Have you every sought support or treatment for your drug use (what? who? where and why?
- Experiences of support or treatment around drug use and/or sexual health services e.g. screening or advice
- What do you need from services?

Focus groups with service providers covered:

- Trends and patterns of use
- Risk behaviours and consequences
- Current service provision and service gaps
- Training and continuing professional development needs for staff

Data Collection

Interviews were digitally audio-recorded, with participant consent. Brief descriptive data (age, gender, sexual orientation) was collected on each participant to provide the context for qualitative responses. Target group interviews were undertaken face to face or by telephone. Informed consent was sought and recorded verbally. This approach allowed participants to remain anonymous. Interviews lasted 30-60 minutes.

Focus groups with service providers were held in three locations (Lothian, Glasgow and Fife). In total 19 service providers participated. Focus groups were organised by setting ground rules to ensure all participants had equal opportunity to contribute and to protect the confidentiality of information shared during the group discussion. Discussions lasted 1-2 hours and refreshments were provided. Points discussed were captured by facilitators on flip charts.

SDF staff with relevant experience undertook interviews and facilitated focus groups as described. Tony Knox, a PhD student who is working in the field of IPED use undertook some IPED interviews.

Data Management and Analysis

All data were transcribed by an experienced transcriber, contracted by the Scottish Drugs Forum, and transferred electronically for analysis. A directed thematic analysis was undertaken in which the researcher (CM) identified and coded initially under broad themes: ‘potential risk behaviours’, ‘information sources’, ‘sources of support and treatment’. Within each of these broad themes emerging sub-themes were identified and the range of experience and views within these described.

There is a bigger pool of data still available for further in-depth analysis. Data from each of the three target groups was analysed separately but using the same approach.

For service providers focus group, notes were organised into themes. From these themes, training needs were drawn out to inform a training plan.

Ethical Approval

NHS ethical approval was received from the East of Scotland Research Ethics Committee (ref 18/ES/0125). Research and development approval was also received from each participating area.

Chemsex

Using drugs, also known as chems, to enhance sex is a broad definition used

"It was almost exclusively unprotected sex. That was very typically that scene. I think that whole disinhibiting factor of drugs and stuff like that helps you rationalise that kind of stuff, those kinds of risks, eh yeah it was rare to see a condom at these things"

Chemsex Participants

Of the nine people interviewed, seven described themselves as gay men and one as a bisexual trans woman. The ages ranged from 27 – 48 years. Key interview findings and associated learning points are presented under five main headings:

i. The type and nature of drugs used
ii. The nature of chemsex
iii. Harms and consequences of chemsex
iv. Information sources and needs
v. Use of services

Note that when quotes are used in this section R refers to the researcher and P to the participant.

The Type and Nature of Drugs Used

Drugs Used

There was some discussion of which drugs or 'chems' (the term drug will be used hereafter) were particularly associated with the chemsex scene (and also some discussion about the definition of chemsex itself). There was acknowledgement that using drugs to enhance sex, was a broad definition. However there is also a particular scene which will be explored after consideration of the drugs used and associated with the term 'chemsex'.

The drugs that were most frequently mentioned by participants were:

- MCAT (mephedrone) also known as 'meow meow' a former 'legal high' that was controlled as a class B drug in 2010
- MDMA (methylenedioxymethamphetamine) also known as 'ecstasy'
- GHB (gamma hydroxybutryate) also known as 'G' or 'liquid ecstasy'. G can also refer to GBL (gamma butyrolactone) which is a prodrug of GHB and is metabolised in the body into GHB
- Ketamine
- Cocaine
- Crystal meth or 'Tina' (crystal methamphetamine) had been used by a couple of participants.
- One participant mentioned ethylphenidate which is a derivative of methylphenidate, also known as Ritalin. Ethylphenidate was formerly sold as a 'legal high' until it was placed on temporary control in 2015 and then was controlled under the Psychoactive Substances Act in 2016. Effects of ethylphenidate are somewhat similar to cocaine.

One participant referred to smoking heroin on one occasion. Other drugs were noted in relation to the desired effect to stay awake, e.g. modafinil. 'Valium' a sedative, was noted to help 'come down'.

The main drugs listed above will be described in more detail using illustrative quotes from participants. Note that when quotes are used in this section R refers to the researcher and P to the participant.

MCAT (mephedrone)

Mephedrone was the most frequently mentioned drug across participants. Some started using this when it was a legal substance that could be purchased in shops. Since the change in the law in 2010 it has moved into the illicit market. It is a crystalline powder and is generally administered by sniffing/snorting:

> "I took a, a few lines [of MCAT], just the way you would maybe snort cocaine or something like that, you know, so it wasn't, I wasn't really thinking about dosage or anything like that, so and surprisingly I was stone cold sober when I did that, usually I've had a drink in my, I'd be a wee bit more disinhibited, and more kind of inclined to say, aye, okay, I'll try it kind of thing, so I suppose I wasn't too nervous about it, because I'd taken other drugs before. I tried cocaine before, I'd snorted other drugs before, so it wasn't something that looked, you know, strange or unusual to me, so although it was certainly more painful, snorting it, than cocaine or something like that, kind of crystally, so that was, that was a new experience, it was, it was a good, it was a very good high, I would say" (117)

GHB or 'G'

The drug that seemed to have a reputation across participants of being 'risky' was gamma hydroxybutyrate. GHB is a liquid and because is it very potent, very small volumes are required, which require precise dosing with a dropper or syringe barrel. As this participant explained there are perceived risks through getting the measurement wrong:

> "The only one that I would say I kind of knew active doses for, and that I was quite careful about, was G, that was always right, time it, you know, how much to take, there was just always seemed to this big focus when you don't overdose on G, and that, you know, like with the, that was, that was very like regimented, because I was quite scared, just because of how I'd seen others, I don't think I've ever seen anyone have a bad experience on G, personally, but I've heard horror stories, so that was always quite controlled" (116)

GHB has been connected with drug assisted sexual assault and can raise issues surrounding consent due to effects of the drug being highly intoxicating where someone may be conscious but may be quite unaware of their surroundings and their behaviours, making them potentially vulnerable and sometimes unable to give informed consent. They may also experience memory loss.

The following quote demonstrates these effects and the harms people can be subject to when using it:

> ".. G is the one I have the least, that I still have an awful lot of, I'm so very wary around, I'm wary around all chems, don't get me wrong, I mean I'm, but G is the one that I've found myself, I've had a couple of pretty nasty experiences, as a result of being given one thing [that turned out], to be another, I've been given too much of one thing, for example on the 27th December 2011, I was raped by someone I knew, and I, he was the partner, the lover of a very, one of my dearest friends, and I'd been given a bit too much G and also instead of being injected with purely crystal meth, it was, there was K in it too, so I was just transported into a completely space, and for the next few hours, I have very little recollection of what went on.." (112)

This same participant later described another incident when they were put in a non–consenting situation because they were under the influence of G.

Crystal meth (Methamphetamine)

A few participants had used crystal meth by smoking it although it can also be injected. This is another very potent drug causing disinhibition:

> " the first time I'd tried crystal meth, first of all I was smoking it, and I had no idea what it was, I knew it was a new in thing, in ******, had no idea of its reputation, away from the gay community, had no idea that it was a, something that was more of a sort of redneck drug in the USA, I just knew it was a gay sex drug and that it could cause, you know, to be, lose any and all inhibitions, which it did, and then the first time I injected it, or it was injected into me, I think I was in the place for about nearly 48 hours, I almost missed my flight home, and I didn't do it again for a long time, about 2 years." (112)

Ketamine or K

Ketamine was mentioned by several participants and one person noted this as the drug they used the most. It can be snorted or injected. It is a potent tranquilliser used in anaesthesia. It has a strong dissociative effect which is described below:

> "mean I use it (ketamine) as a party drug, as much as I use it, I have never used it in sex, but I mean again, you know, it does that thing where it sort of loosens up inhibitions, so there's certainly been a couple of times where I've noticed that it altered my judgement of what would be consider safe sex" (114)

Cocaine and MDMA

Drugs such as cocaine and MDMA were mentioned by several participants. Perception of these drugs as 'chems' was mixed. Some identified them as being the initial drugs they first started using and noted them being used in sexualised settings or in the mix with more traditional 'chems'. Other interviewees saw them more as drugs used in wider settings and not specifically for chemsex.

> "I'd taken cocaine in a sexualised context several times prior" (112)

> "I'd taken ecstasy on most of my nights out, that was in my early twenties, pretty much most of the time then I was going home with guys" (113)

> "At other times there has been maybe cocaine or MDMA or speed or something like that, one of your typical kinda party drugs but it would always be in the mix with other things as well" (117)

> "R: So if I say chems to you, what are the drugs that come to mind?
> P: Certainly ecstasy, MDMA, coke, speed that sort of thing" (118)

Learning Points from Drugs Used

- Mephedrone can be painful to snort due to crystalline formulation.
- Potent drugs like GHB require careful dosing and accurate measurement of small volumes. It would be worth considering how this could be made 'safer'.
- Poly substance use is common and certain combinations may raise particular risks e.g. GHB and ketamine both have strong dissociative effects that might make people take more risks than they otherwise would and raises issues around consent for sexual acts.
- Other drugs such as cocaine and MDMA may be considered as chems by some and their role in widening drug use to the more traditional chems or in sexualised drug use generally may be

Routes of administration (oral/ booty bump/ slamming etc)

Most drugs are either taken orally or snorted. One route of administration associated with the chemsex scene is a 'booty bump'. This is anal administration in which a drug is inserted via a plastic syringe barrel (without a needle). This was described by a couple of participants only:

> "P: then I remember on a few occasions when I got a booty bump, that I was quite particular about making sure it was a clean needle, is it a needle…………
>
> R: A syringe.
>
> P: ………….syringe, syringe, yeah, you can tell I'm, I leave all the proper stuff to other people, so I was quite intent on making sure it was like fresh and all that, but you don't know what people are doing when you're out of it, you're that out of it, and my paranoia would set in a lot" (116)

Injecting (slamming)

Few participants revealed injecting as a route of administration, indeed a few noted they would never do this. However one participant, who initially said he did not inject, described an experience when he did:

> "I never slammed [injected], except one occasion, and I got someone to do it for me, and again that was, I think, it was, I'd been out for a couple of days, and then I went home to my own environment, and then I was just like, I'm not finished yet, I didn't want to be alone and all that nonsense, so I found a guy who was up and about on the app and I went to his house and he was slamming already, and I got him to, to just, to do it to me as well, and as far as I know that was MCat." (116)

As this quote reveals this act of injecting was linked to the potentially vulnerable mental state of that person at the time.

Another participant did share information openly about injecting, in this case it was mephedrone:

> "The big one was definitely MCat, but it was more and more quantities of it, and eventually I injected that as well as you know, slamming it, they call it" (117)

The risks associated with injecting are presented later.

Patterns of use – frequency and dosing

Use of drugs in the context of a sex party or even a small group were generally associated with re-dosing over the period of a night:

> "like it could be quite a lot over the course of a night, but I wouldn't know exactly, and like any kind of quantities or stuff" (111)

As this person indicates this might mean that the quantity of substances used in a time period could be quite high, but more importantly the individual might be totally unaware of how much they are consuming. Some 'sessions' could last several days so even more drugs were consumed:

> "Oh in a session, oh gosh, I mean one could easily take, it was T [methamphetamine], over a weekend, you know, late Friday through till you know, late afternoon Sunday, perhaps, and go through oneself, maybe just over half a gram" (112)

This was generally the case with whichever drug(s) participants were using as this person suggests:

> "I think the only thing I have sense of that (dosing) for was MDMA, yeah, never really considered dosing for any of the other drugs, it becomes a lot more important, if you take larger quantities than I do, I think, it will be much more important if you slam it [inject], but I don't tend to ever do that" (114)

> "R: Okay, and so you're saying you didn't know much about it, would you have known like what an active dose was, or anything like that?
>
> P: No, and I probably still don't, if I'm being honest, an active dose." (116)

Learning Points

- There is a lack of awareness of safe and appropriate dosing.
- Rational decision making is adversely affected by the effects of the drug and the length of time people use drugs in a 'session'.
- Guidance of how much is 'safe' (with all the usual caveats on unknown purity and content for illegal substances) for each administration and over a period of time is required.

Sources of drugs

The source of drugs was largely through known suppliers/contacts.

> "like I had regular, I had about 3 or 4 regular contacts that I would use, but certainly if that was exhausted, and you know, you can't get anyone and all that, it would just be whoever the hell can get it for you." (116)

People tended to bring their own supply to parties. There was mention of using apps to get supplies by one participant:

> "Yeah, getting them through the apps was really common, like I would probably start off my, say I was on a weekender, I would start off with what I had, that I got from someone I knew, that's how it begins, and then we'd start using that, maybe the other people that's with us, they'd have the bit they came with, and then inevitably whatever you think is going to be enough, never is, and you then start to run out, so then you'd be onto the app to get more and people would just bring it in" (116)

Only one person mentioned using the dark web:

> " I mean stuff I'm taking now, all the stuff I have taken, taken recently, that it's, it's MDMA off the dark web, so it's not actually proper MDMA, it's, it's, it's fake" (118)

The Nature of Chemsex

Motivation and context

The motivations for chemsex ranged from maximising sexual pleasure, overcoming inhibitions to increasing confidence:

> ".. everyone has different reasons why they're doing, my reason is that it gives me a bit more confidence, and makes me feel good for that period ... I've got a lot of, you know, health issues" (115)

However the purely pleasurable nature of chemsex, the hedonistic element, was very evident in most interviews. For some this was also an escapism and for others there was also a simple desire for company.

Although generally associated with MSM, one participant was aware of use in the heterosexual community:

> "a couple of houses are now taking it and injecting it, and so it's not purely the province of the gays, and they're using it exactly the same, they're using it in a sexualised context" (112)

Some people just used drugs with their partners or small groups of known people. Some used apps like Grindr to meet up with people willing to also use chems. Icons would be used to identify as being

'chem-friendly'. Others described chemsex at bigger parties. Chemsex 'parties' were often described as quite informal and ad hoc rather than planned:

> "I used to go to the ***** club in E********, yeah, just a group of friends, we pretty much sat during the day, we'd go and buy some stuff, and use for the night out, then you would go back to an after party, to meet more there, and you meet somebody at the party, or go back to someone's house, and a group, and somebody would say, yeah, I've got this, do you fancy coming to mine or." (113)

And:

> "So I don't go to sex parties, not generally, I just, it's not an environment in which I think I'm going to enter myself, or feel good about afterwards, but usually it's a result of hanging out with friends, friends of friends at parties, or going on a night out and having an after party, or meeting individual people off Grindr say, or some of the apps, so I just thought of something else that I should probably mentioned, but I, I don't really drink very much, so alcohol doesn't really factor into any of this." (114)

As this participant highlights, apps like Grindr are used to link up with people. Bigger group chemsex parties were also described:

> "Yes, so as things developed, so it would go onto like a, it would be the sex party scene that I was right involved in, be having sex with, I use the term sex loosely, because obviously you can't always do certain things, but I would be engaging and like stuff with anything between 3 guys and over, well maybe over 10, and it would, could go on for one night, or it could be, if it, if it was a long stretch, a particularly heavy session, it would be a good few nights, so kind of 3 nights at least and into the next days, and just kind of out of it" (116)

Effect of drugs on sexual practice

For some the link between drug use and sex is so strong that they completely associate sex with drug use and never have sex without drugs:

> "No, I don't really have sober sex at all now, I don't know the last time I had sober sex, if I'm being honest with you, so I don't, I don't remember the last time I had sober sex, I don't know". (115)

Breaking this association may be a way of moving forward for those wanting to address chemsex that has become problematic. One participant described how chemsex had affected his sexual experience.

> "I mean I feel now it's kind of ruined my sort of sexual experience, I'm trying to sort of, you know, I don't kind of hit the same highs as I do, when I'm on the chems, and it's, I've kind of lost my enjoyment, so I'm trying to, I'm trying to stop having the chems for sex, but every now and again I do have, I do have just an urge, so it's like, so, I mean probably I try not make it more than once every few months, you know, I use chems as sex, but then it's like a, it's like a 2, 3 day session for me, so I've got to, I've got to kind of fit it into my diary, so make sure I've not got anything, you know, anything on". (118)

As this participant described, he has to plan ahead for his chemsex sessions.

Learning Points on Sexual Practice and the Nature of Chemsex

- Motivations include maximising sexual pleasure, overcoming inhibitions, increasing confidence, coping with mental and physical health issues. Identifying and understanding these motivations are important for assessing potential harms (if any) and identifying the most appropriate information and treatment options.
- The association between drug use and pleasurable sex is very powerful. Some people may need help in dissociating the two (if they want to). Interventions which focus on pleasurable sober sex may be useful for people experiencing compulsive chemsex patterns.
- Chemsex sessions can last extended periods of time (several days). This could have a detrimental impact on physical and mental health and wellbeing.

Risks Taken

Several participants recognised they had taken some risks in relation to drug use and sexual activity:

> "I took risks with the, the amount, how frequently I would take the drugs, and with the amount as well, yeah" (116)

Regarding drug use there was considerable recognition that GHB was a more 'risky' drug because of the narrow dosing margins. It is a liquid formulation and the active dose is very small so it is easy to overdose.

> "so G, I am extraordinarily wary of, and other people hand you bottles and things, I look, no, no thank you, it's not something I, in the right doses, the effect it has can be absolutely euphoric, and makes the sex extraordinary, particularly in, when combined with the crystal meth, this is why people take it, but get the balance slightly wrong, and it makes people very, vomit, you can overheat very quickly, and I've seen numerous people pass out, and I've had a couple of friends, for whom, when they passed out, they never woke up, and that's very scary" (112)

Risks associated with drug use were also related to altering judgement and lowering of inhibitions. Although not explicitly mentioned, but alluded to, in the following quote this could extend to not using condoms and putting oneself at risk of sexually transmitted infections.

> "I mean I use it (ketamine) as a party drug, as much as I use it, I have never used it in sex, but I mean again, you know, it does that thing where it sort of loosens up inhibitions, so there's certainly been a couple of times where I've noticed that it altered my judgement of what would be considered safe sex, or appropriate things to do, more so than I would ever have done with any of the other 3" (114)

Condomless sex was a theme mentioned by multiple participants to varying degrees with some participants suggesting that most of their sexual encounters would be without protection.

"It was almost exclusively unprotected sex. That was very typically that scene. I think that whole disinhibiting factor of the drugs and stuff like that helps you rationalise that kind of stuff, those kinds of risks, eh yeah it was actually rare to see a condom at these things" (117)

Whilst some people 'rationalised' condomless sex to suit their own behaviour others were more candid in describing the motivation as being personal pleasure, including the added psychological appeal of condomless sex.

"I would generally not use a condom. At the beginning I was quite fair if someone wanted to use a condom, now I still enjoy it but sometimes I discriminate, not in a proud way but especially if you're high and a bit impatient, I'll be like right you don't have a condom and they go away to go and get one and I'll be like no, do you know what?, this is a club with like 800 men in it, I think I can find someone else. Again I'm not proud of that attitude, but when you're there and then you just don't have time for that. Preferably without a condom by far is just so much better, not so much physically, because especially if you're not looking, you're not seeing what's going on behind but it's psychological. If I'm the top then definitely I don't use a condom, no..because it doesn't really do anything for me." (119)

Drug use could also put you in a vulnerable position as already mentioned in relation to use of GBH by one participant who had been raped. Some participants identified risks relating to other people preparing their drugs for them. *"Yeah, yeah, didn't always have my eye on what was going on" (116)* – it was difficult to actually see what was being administered if this was being done by someone else as more often the case in a booty bump. They went on to say:

"You don't know what people are doing when you're out of it, you're that out of it and my paranoia would set in and I'd be like Oh, was that the dose they said they gave me, is that what I took, did they give me more? " (116)

Risks of other people preparing drugs was highlighted by others, this participant discussed the risks of this where the person preparing was intoxicated.

"Initially I wouldn't let anybody else prepare mines for me, so I'd try and keep a sense of control with that but other folk would allow people to do that for them. I don't think I ever saw anyone deliberately give someone too much but when people are mad with it they're no quite...and all it takes is a half a mil more and they're dunted out for 6 hours." (117)

Sharing equipment was another risk identified by some, although this seemed to be more associated with snorting.

"I shared tooters, didn't even think anything of that" (116)

"Well snorting, maybe sharing the same note or something like that yeah" (117)

Only a couple of participants had experience of injecting (slamming) and described using clean injecting equipment.

"as much as I was using you know, clean equipment and that, I think I was, was trying to hurt, you know, I was having a hard time, I can see that now when I look back, but I don't think, I think I was, I wasn't trying, I was taking a lot of risks with myself, because I wasn't really

valuing myself, I think that is what was underlying it, so yeah, I took a lot of sexual risks, yeah, I was a bit more controlled in terms of using clean needles and all that kind of stuff, and I never went over, over the score with, with the G, and I used to always prepare that myself, as well, unless, there was a couple of folk that I got on really well, that I really did trust, I would let them sort it for me, but I wouldn't let anybody do that, so I was, I was kind of controlled with that, but the sexual risks, I was taking, they were outrageously risky. (117)

However, as this participant describes, there was considerable risk taking in relation to sexual activity. This participant was very reflective about the reasons for such risk-taking believing there was a self-destructive aspect to his risk-taking behaviour. Another participant, when asked if they feel like they are taking risks, responded *"I probably am, yes"* (113)

Prophylaxis – PrEP (Pre exposure prophylaxis) use for HIV

Awareness of HIV risk seemed reasonable as multiple participants noted there were people who are known to be HIV positive amongst those using chems. Most participants mentioned PrEP i.e. the pro-phylactic medication used to reduce the risk of HIV transmission. Perceptions of risk may be affected by the increased use of PrEP amongst MSM as the following quote indicates:

> "I don't think I do anything particularly risky, there are a couple of times when I've had sex with somebody who wasn't on PrEP, and I spent maybe a short amount of time fucking him without a condom, if that makes any sense, that's the only obvious risk I can point to". (114)

It was clear that risk, in terms of unprotected sex, was quite common with several participants describing having had unprotected sex as has been discussed earlier.

When asked if HIV status was ever discussed:

> "It never really comes up in a group setting, it's bad to say that, but like I think it's always almost assumed that people are either clean or they know enough that it's fine, or that they'll be on something like PrEP." (111)

People make assumptions that other people have made rational and planned decision about HIV status, use of PrEP and use of condoms during sex. However, this was clearly not the case.

> "Obviously I mean, obviously I've always sort of been a bit risky with sex, like you know, unprotected sex and all that, and, but then I've also been very conscious of my sexual health, so I've always been, had regular check-ups with the S********, and obviously I've caught, have had few, you know, infections that I've had cleared up, but then for the last, for the last 18 months, I think, no almost 2 years, the past 2 years I've been on PrEP, so that's obviously brought down the risk of, of HIV infection so I mean, to be honest, I probably do have more riskier sex since I've been on that, than I don't, which is probably not the best thing to say, but yeah. (118)

As this participant described, PrEP use over the last 1-2 years has increased and this reduces the risk of HIV, but what is not explicitly mentioned here (or in other interviews) was that this does not protect against sexually transmitted infections and other BBVs including hepatitis C. Some participants discussed acquiring STIs as a result of condomless sex.

There was also discussion of U=U, those with undetectable viral load being unable to transmit HIV as a factor in discussions about status and condomless sex, but one participant acknowledged the issue of adherence to antiretroviral medications:

> "If that guy is detectable and obviously infectious because he's not taking his meds (which I think is stupid anyway) he might be having this consensual conversation with me, but I'm pretty sure there are other people out there who are not even talking about the topic and will have sex with him sooner or later" (119)

Learning Points on Risk Behaviour

- Perception of risk within the chemsex community may differ greatly from perception of risk by staff supporting clients in services. Some form of sexual risk taking appears to be relatively common.
- Excessive risk taking may be part of self-destructive behaviours linked to shame and stigma and requiring more in-depth support or counselling.
- PrEP may have influenced people's perception of risk and resulted in lower condom use.
- People make irrational assumptions that other people do not take risks and/or sexual health and BBV status is known by their sexual partners whilst taking considerable risks themselves by not using condoms.
- The message that PrEP only protects against HIV – it does not protect against sexually transmitted infections and other BBVs continues to be important.
- It is important for services to continue to stress condom use is the only way to protect against sexually transmitted infections and BBVs.
- PrEP is widely used. Those working in sexual health services need to be very familiar with dosing schedules for different patterns of use in order to ensure PrEP is being used appropriately.
- Adherence to PrEP or ARV medications could become challenging if individuals are using chems. This may lead people to believe they have a greater level of protection against acquiring or transmitting HIV than they actually have.

Harms and Consequences of Chemsex

The harms experienced by participants included acquiring sexually transmitted infections (as already noted) as well as negative consequences for mental health, work/employment and financial situation. Sexually transmitted infections could have severe effects if left untreated:

> "I got, I got gonorrhoea a few times as well, so there was the associated things with that, like the, the sweats and sickness, diarrhoea, and weight, that brought on weight loss as well, till I got it treated properly, so yeah, there was that too, and I contracted chlamydia as well, and syphilis, so, yeah" (116)

There were financial consequences with considerable amounts of money being spent on drugs:

> "… I think we worked out that we'd done about 5 grams each, if I remember right, but it's hard to say, it's really hard to say now, but sometimes it was just astronomical amounts and my, my cousin, at the time sold cocaine, so if I was taking that, whether it be for chemsex or not, it's just like, I remember I owed him once £800 on a Tuesday morning, after being on it from the Thursday night, so that was quite a lot" (116)

The side effects of some of the drugs used, in the manner used, were acknowledge with one person particularly noting extreme paranoia in people he was using with:

> "the risk that someone might be, especially with crystal meth, the paranoia, that can be, can set into some people, is really, really scary...on one occasion, having to call the police...obviously because I felt my physical safety, my home was at risk" (112)

This participant also explained that he felt paranoia was associated with certain drug combinations:

> "I would never take cocaine and crystal meth, essentially two things, it would be fighting against each other… and I see people do that, and the paranoia kind of kicks in its, is dreadful" (112)

This individual clearly experienced or witnessed frightening paranoia that caused him to moderate his own drug taking behaviour.

Other mental health consequences were mentioned by several participants, particularly anxiety:

> "drinking water regularly, not too much, and if I felt like I was getting too high, just stop and if I felt like I was feeling sort of anxious, just try to control my breathing, and I've always been quite conscious of stuff like that" (113)

The aftereffects of a chemsex session were both mental and physical:

> "really paranoid, paranoid, very paranoid and anxious, and on edge, jittery, that kind of thing" (116)

And another described a form of exhaustion:

> "I just feel like drained, and it takes me a good couple of days to get back to sort of my normal self" (113)

However, it also went beyond this for a couple of people who also reflected on their motivations for using in the first place. This was revealed in one exchange when asked if “feeling crap” was mental or physical:

> "Mentally, yeah, you just, you just feel like, I don’t know, a bit, bit disgusting... I don’t think necessarily it’s a bad thing that...people do, group stuff, when it’s for the right reasons...but you could say like at least 90% of everyone there ...we’re just unhappy in some way... and just we’re using sex and drugs to feel better, even if it was briefly" (111)

and when asked why they felt disgusted:

> "Just because it seems a bit like, just really promiscuous and a bit slutty, and you know you’ve taken a kind of a risk" (111)

When asked if the individual had any knowledge of the drugs they took, prior to use:

> "Not at all, none at all, I was extremely green, extremely" (112)

This led on to discussion of sources of information that people had used in the initial stages of chemsex and on an ongoing basis.

Learning Points on Harms and Consequences

Commonly experienced harms that people should be warned of were:

- STIs
- paranoia
- anxiety
- mental and physical exhaustion
- feelings of shame or disgust in oneself
- financial issues
- impact on work

Knowledge of sources of help in coping with these effects is required.

Information Sources and Needs

Sources of information

All participants were asked about the sources of information they used about chemsex such as drug information, dosing etc. Information largely came from word of mouth, friends/partners, and the internet. One of the older participants described finding it difficult to find reliable information online in the past but over time became aware of online resources.

> “I began to look out, look out for it online, and reliable sources of information were, were hard to come by...I basically did find some material, Tumblr... was a very good source for that kind of information,... particular about things about keeping hydrated, about how to manage the come down, what are the things you should and shouldn’t mix” (112)

However, several participants specifically mentioned the website FRANK. Indeed, this was the only specific website mentioned by participants:

> “I would more speak to people about like what it would be like to take, I guess sometimes I looked at FRANK, just to see like, you know, looking out for water and things like if you have taken too much, or like what could be the bad side effects and things”. (111)

This website seemed to be one of the main online information resources as it was the only website mentioned by several participants. One participant mentioned Tumblr, and another mentioned “Know the Score” but other references to the internet were generalised.

Information needs

There was a lack of knowledge about where to access information. The lack of open information was recognised by participants. It was speculated this was related to the illegal aspect of chemsex:

> "there isn’t much information about chemsex, you know, it’s not, you know, it’s, it’s, I think it is a kind of consensus it’s illegal, therefore it doesn’t go on a lot, but you know it’s quite the opposite, it’s like saying, people don’t take cocaine in this country, because it’s illegal." (118)

When asked about what specific information might be useful, the following were mentioned: drug information including dosage advice; recognising an emergency; the effects of sexually transmitted infections and where to get mental health support such as counselling.

On drug information:

> "information earlier on about the risks and then about maybe why I felt the need to do it, because it did come in time and it was helpful to realise to know that I’m doing this for all the wrong reasons" (111)

> “it would have been useful to have an official kind of guide on dosage... because I had to take my lead from other folk... you could get a guide on dosage, that’s reasonably safe, that would be a harm reduction, so that folk have got a legitimate source of information” (117)

Specifically relating to the impaired judgement caused by the effects of drugs which raises issues about whether sex is consensual:

> "the risks of you know..… inhibitions are lowered, so you're not being as protected… issues around consent… real dangers of overdosing" (111)

Recognising an emergency was noted by one person, especially in relation to GHB:

> "I'm unclear about when someone unconscious on GHB becomes a medical emergency or not." (114)

One participant felt there was good information available about sexually transmitted infections but that this could still be explained and expanded on by covering the effects of these infections:

> "the STI information is always really good, and they didn't discuss that a lot, I think it would be more useful to have more information about the risks of chemsex and stuff...it's not as much information as say like, you know, this STI does this" (111)

Counselling and support services:

> "it would have been useful to feel that you could speak about it, and get the right advice, like so you could say yeah, this is something I do, they [a service] accept that, it is something people do, you know, whether they like it or not...here's what you can do to be safer in those environments, and here's what we suggest you do and do not do" (116)

The format of information

The format of information was also considered by some participants, one in particular who suggested films and documentaries would be a good media to impart information.

> "like even an app that somebody could log into and get a bit of support that way, would be really good… films would be good, documentaries" (116)

Film and animations were suggested as useful by another:

> "Videos are great… especially if it's something that's non-fiction, as in fact based, videos are so much [better] especially if they are done well (some videos are awful)" (119)

Others considered support groups might be a way to share information:

> "talking groups, certainly, chemsex anonymous... my worry about that, would be it would turn into some kind of knocking shop... but I think if something facilitated by someone who understands... hear other people's stories, because those really help, those really help... I talked about camaraderie earlier, there's a camaraderie in wanting to stop this kind of thing too... techniques that those who have weaned themselves successfully away from it, or are able to kind of limit their intake" (111)

One person had heard of services being present at a chemsex party to provide harm reduction information:

> “friend of mine was telling me about a party that he was at where somebody else was there, kind of, just hanging out, who worked for a sexual health charity, but, who was kind of in terms of in communicate, he was just there at the party, just to kind of like talk to people, I wonder if volunteers of that kind are more, are of a sort of useful nature, if that makes any sense” (114)

In terms of how information should be presented it was noted that terminology used in chemsex can glamorise it. He used the example of injecting (referred to as slamming):

> "they’ve (a charity) got their own terminology for it, to make it sound more acceptable, if someone said, I’m going to shoot up, no way, no way, no, if it had been put to me in those terms at first, I probably wouldn’t have done it...straightforward, don’t glamorise, and be straightforward" (111)

Again, when considering the staff in a service:

> "when I first told him, he said right, okay, you’re slamming, I suppose it takes away a whole conversation... you don’t have to explain... he was so open and so, there was just zero judgment, it was just so pragmatic... he knew what he was talking about, knew all the kind of questions to ask, was prepared to listen to me talking about it, and help me find solutions, help me find the right kind of help... genuinely there to help me... other encounters have been a bit preachy in terms of, you should take more responsibility for yourself... if they’ve got that kind of attitude, then I’m no going to tell them that kind of stuff" (117)

This open, pragmatic and non-judgemental approach was welcomed and recognised as important in order to be able to engage and provide useful information.

Learning Points on Information Needs and the Format of Information

- Practical drug information about the drugs in use including dosage advice and information on overdose is important.
- Knowledge on the existing information sources is limited.
- The terminology used needs some careful consideration to ensure glamorising language is not used (e.g. slamming for injecting, chems for drugs).
- Keep information factual.
- Consider novel delivery of information e.g. films, podcasts, animations etc.
- Role of peers in education/ assertive outreach could be further explored.

Use of Services

Experience of services

Most participants had had involvement with sexual health clinics/services and a few had had experience of injecting equipment providers. A couple had had access to mental health services for counselling. The experience of sexual health counselling had been very positive, when experienced:

> “when I spoke to like the sexual health counsellor, that was really helpful...like, it was good to kind of talk through... this probably isn’t like good behaviours and this isn’t being done for like the best reasons, that was really useful, and it was, it was good to talk through like even wider issues that could contribute to like why I was like, it was sort of like self-esteem stuff, and things like that, so that part of it was really good.” (111)

Others had found it very challenging to access counselling and either were not offered or were subject to long waiting lists for the service.

> “When referring to support services "doctor never offered me anything, the S******* offered me counselling, but they said it would take 9 months" (115)

The experience of sexual health clinics had been mixed with some having non-judgemental experiences, as one participant reflected:

> "that’s one thing they [staff at sexual health clinic] don’t necessarily preach to you, because they don’t want to, you know, put you off... , they don’t want to, to, you know, but if I went up there every time and got a lecture, then I would, I’d think I’m not doing this anymore... to me they hit at the right spot, the advice is there, there’s advice on the walls, there’s leaflets you can pick up, there’s condoms that you can get free... they advise you... at the end of the day it’s up to yourself" (118)

However others described situations where they felt there was a lack of knowledge and/or some judgement as described below:

> “I didn’t always feel comfortable bringing it up, because I felt there was a bit of judgement there, if I’m being completely honest, I mean, yeah, I’ve never felt that I could, that it’s being brought up in this, I didn’t feel like it was like a safe environment to talk, I felt it was more the finger was getting pointed" (116)

Participants were asked if they had a preference for male or female staff but in general no strong preferences were expressed. It was articulated by several participants that the way staff treated you was more important. One participant expressed a preference for a woman:

> "I don’t feel comfortable going into details with a guy, especially if they’re straight, it makes me feel awkward...I feel a bit more comfortable speaking to a female." (113)

Trust in services

One individual seems to show real distrust in record holding:

> "it all gets stored in their, their magic database, so yeah, I wouldn't really feel comfortable discussing anything more sensitive, and especially since it was drug use" (114)

This could be particularly problematic if it caused delays in accessing treatment such as PrEP as happened in the following situation:

> "they [the sexual health clinic] were saying, like obviously like you're quite late into the, like the maximum was 72 hours, because it had happened like early Saturday morning, and I didn't go in until Monday, but it was because of the like fear of having to go in, to like A&E and have that on like a record that is accessible widely" (111)

Fear of being judged underlies much of this apprehension about using services:

> "It can get a bit embarrassing especially if you're unlucky and you get the same doctor twice." (119)

This extends to the use of needle exchange as was described by one participant who needed larger quantities of needles:

> "I just felt that I was being really judged by it, but other times, it's been alright, but to save that embarrassment I just get them, I tend to just get them myself." (115)

This participant went on to describe use of a particular pharmacy-based needle exchange:

> "the person serving me at the time, really wasn't, you know, wanted to talk to me, you know, show me what I needed... it was quite unpleasant... I'm not saying that I'm going in here to have a positive experience, you know, but I didn't expect to be kind of put down... I did feel like that and it was horrible, so I've not been back since [to a particular pharmacy]" (115)

Lack of basic interpersonal skills played a role in making this person feel very uncomfortable. People who use chems for sex, particularly if injecting, may already feel marginalised and judged. There may be an element of self-stigmatisation that makes people particularly sensitive to any possible negative cues from a service provider. This sensitivity was also evident in interactions with a sexual health clinic for one participant. When asked why they did not go through with certain referrals from the sexual health clinic:

> "I was a bit embarrassed, yeah, if I'm being honest, I was embarrassed about it... if I go for, to the S******** for a counselling appointment about my sexual exploits, they'll trans, they'll cross reference... then start saying right, oh right, so did you have sex with 10 people... who are they people, have they been tested, maybe we should get them in, I thought it was going to open up a can of worms, but I think a lot of that was just my own paranoia at the time" (116)

The same participant suggested thinking about how services ask questions as well as giving the rationale behind asking those questions.

> "I don't know if it's ever been said to me, we're asking this and please be honest and it's not to get you ..maybe you know a bit more of an explanation why it was being asked would have been beneficial" (116)

Another participant highlighted use of language as being important citing his experience of getting blood taken in a sexual health clinic and being asked about previous history of injecting.

> "She said did you used to jag up and of course it's just a way of saying things but I thought, really? But I suppose that's just if you're used to people that inject that's just what you say, if you're using heroin that might be the slang that you use 'jagging up' or whatever else but I remember my toes curling slightly and thinking ok." (117)

Learning Points on Services

- Data protection concerns can prevent people accessing services and treatment. Explaining rationale for asking certain assessment questions and normalising this may be an important part of reassuring clients when they are disclosing information.
- People obtaining clean injecting equipment for chemsex based drug use may be particularly sensitive to anything that could be interpreted as 'negative' treatment or judgment. Staff need to be very sensitive to this.
- Staff must be aware of potential embarrassment, shame and fear of judgement in chemsex clients.
- Consideration of how questions are asked about chemsex, use of language and informing clients of the reasons why the questions are asked is useful to overcome barriers to disclosure
- Staff should be alert to potential paranoia as a side effect of the types of drugs used. This can influence client behaviour and perceptions of staff behaviour.

Service Provider Perspective (focus groups)

Significant gaps in intelligence and evidence on chemsex was mentioned in both Glasgow and Lothian focus groups. By their own admission a lot of anecdote informed service provider knowledge rather than research based evidence. There was a perception by some that chemsex was increasing but this was not based on data and participants recognised they relied on anecdote. Injecting prevalence appears to be low although there was again a recognition of the difficulty of assessing the scale through IEP services.

There was a variety of settings for chemsex discussed in the focus groups ranging from couples, to small house parties to larger scale event parties sometimes after clubs or arranged online. Focus group participants mentioned several apps for arranging hook ups online that had not been mentioned by interviewees these were: (as well as Grindr) Squirt, Hot Mess, DILF. DILF and Hot Mess were believed to be for travelling and pre-planned events.

Regarding risk behaviours there was agreement across groups that HIV was a risk. This was evidenced in several ways. It was mentioned more 'older' men were involved in chemsex because they were HIV positive and felt stigmatised in the broader gay scene. Some might be on antiretroviral medication but could forget to take it. It was also noted that others might deliberately seek out parties where there were HIV positive people to play 'Russian roulette'. Condom use was considered to be falling thereby increasing risks of STI and BBV transmission.

A range of settings was suggested for testing for BBVs, and HIV in particular. This would allow choice as some service users value anonymity, and so would prefer NHS services, whereas others would prefer services where there was a perception of there being less stigma i.e. those provided by MSM. Hepatitis was not considered to be on the radar of MSM, the focus being entirely on HIV, of which they were very aware. There was little mention of other STIs by focus group participants.

Consent issues were discussed and it was considered that consent could be blurred or deliberately not sought. Indeed, assault was believed to occur and with chemsex this could be more violent and more prolonged because of the effects of the drugs. People might not be aware of being assaulted until the next day. Rape was perceived to be under-reported. Mental health and counselling services were needed to help with issues of consent and assault as well as financial issues.

Cocaine and how it is viewed was raised and needs some particular attention in Glasgow and surrounding areas where there is a rise in HIV through cocaine injecting. This is not necessarily in the MSM and chemsex populations but there may be some overlap with other cocaine users. It was perceived in all focus groups that cocaine was used widely and was not necessarily considered to be part of the chemsex scene by all of those involved in chemsex. Further information and education around cocaine was considered important.

Lack of knowledge of chemsex in more generic services including generic sexual health, GPs and A&E was discussed in Glasgow and Edinburgh. Participants noted that training and information provision was delivered in the more specialist services however since MSM will often access generic services, sometimes exclusively, there was a recognition that there was need to provide training for staff in these services as well. It was also noted that ongoing refresher training and making use of different formats, e.g. masterclasses where guest speakers are invited in, was of benefit to experienced staff. The importance of knowledge exchange in face to face training was also identified.

Disclosure of involvement in chemsex was perceived to be difficult to address from a service provider perspective. It was recognised that chemsex questions had to be asked in the right way to be able to engage people and encourage an honest response. Challenges in assessment and getting an honest disclosure included clients seeing different workers each time they attended; not being given or understanding the rationale for being asked certain questions; clients feeling shame around chemsex.

Notes from focus groups are presented in the appendix.

Key Findings on Chemsex

Despite only recruiting nine participants for interview these interviews proved to be very insightful and full of detail that can be taken forward into training resources for services. There also appeared to be various common themes across interviews, allowing for some conclusions despite the small sample size. The challenges in recruitment highlight the overall issue with chemsex in Scotland, that to an extent it may be hidden in services and a lot of the existing prevalence data fails to capture information that is fed in more anecdotally. Indeed from some of the interview participant feedback, it was suggested that there was often reluctance to talk to services about chemsex or engage in research due to perceived judgement, while many of those actively engaged in chemsex may not feel it is problematic for them. The role of pleasure in chemsex was something clearly identified by the majority of participants and therefore services and research which is focused on harms may not be appealing to a large section of this population group.

Focus group discussions added further depth to information gleaned from the interviews and there were common themes. Risk taking behaviours particularly around HIV and reduced condom use as well as increased reliance on PrEP were evident. Issues of lack of consent are particularly concerning as there were reports of serious sexual assaults which could be more violent and prolonged due to the effects of the drugs used. Taken together with the reluctance by some men to approach services due to shame and fear of being judged means there will be a group of people with unresolved trauma. Difficulty accessing specialist counselling and long waiting lists were identified across interviews and focus groups. Where sexual health counselling had been experienced it was well received. An expansion of sexual health counselling and access to general mental health services to support this group is recommended.

There was little mention of GP service use and service providers said they rarely got referrals via GPs. This is an area of access to support that could be further developed. To do so GPs would need appropriate training. Service experience appeared to vary significantly dependent on whether services were more specialist and had specific knowledge. However there was a recognition by staff that clients may not always come to specialist services and therefore there was a need for training targeted at more general services. There was also acknowledgement that refresher type training, with the chance for knowledge exchange, was useful even for the most experienced of staff.

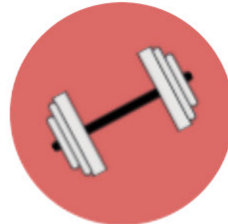
A variety of information needs for service users was evident. This ranged from practical and factual information about the drugs used, dosage advice and overdose guidance to information on harms and consequences for people who experience more problematic use, as well as STIs

and BBVs including hepatitis C. There was a variety of suggestions put forward regarding information formats including online resources and use of film. The role of peer education appeared important given the majority of people engaging in chemsex get their information from peers and sexual partners. Service users who did not experience chemsex as problematic and who therefore may have a different perception of risk need non-judgemental information that acknowledges motivations such as pleasure as well as the challenges in engaging in sober sex.

Challenges in assessment and integrating questions in to more generic assessments were clear. Honest disclosure was more likely where people felt accepted and were asked questions in the right way. Given the evident anxiety in the chemsex community around stigma and information sharing there needs to be work done to educate the community on why certain questions might be asked and what happens to their personal data in different situations.

The overall definition of chemsex is variable and misunderstood across service users and services. The role of other drugs and recreational use of substances in chemsex requires further exploration. Cocaine use needs some particular consideration. Participants often reported cocaine use but did not associate it with chemsex particularly. The additive effect of cocaine on top of other drugs increases risk and there is clearly a need for information on this. A wider definition within Scotland that goes beyond the traditional drugs of mephedrone, GHB and methamphetamine and simply involves sexualised drug use may be useful to consider and may go some way to help reduce gaps in information about prevalence.

Image and Performance Enhancing Drugs



Using Image and Performance Enhancing Drugs, such as steroids

"promote the (specialist) clinics more, because I had no idea there was one that you could go to, that IPED clinic, i'd no idea, until you told me"

IPED User Participants

Fourteen interviews were undertaken with IPED users. The age range was 20 -58 years with three being long term IPED users over 50 years old, and, in contrast, eight being in their twenties some of whom were relatively new to IPED use. Two interviews were conducted by phone and the remainder face to face. Most were white Scottish (one British and one Eastern Mediterranean). One person described themselves as bisexual and the remainder as heterosexual. The spread across the country was also good giving a range of experience and perspective. The three older IPED users were considerably more talkative and willing to share their experiences than the younger users.

Note that when quotes are used in this section R refers to the researcher and P to the participant.

The Nature of IPED use

Drugs used

Anabolic steroids are used because they build muscle. Steroids used tend to also have androgenic effects as well in that they mimic the action of testosterone. There are a number of natural (e.g. testosterone) and synthetic (e.g. stanozolol) steroids. Not all steroids are orally active so some need to be administered by injection. Oral steroids pass through the liver where they are metabolised. Oral steroids are usually taken daily whereas injectable preparations are used once or twice a week. The drugs mentioned by participants are listed below, divided into oral and injectable preparations.

Oral drugs/preparations

- Oxandrolone (AnavarR) an oral steroid that has been available for several decades
- Masterone (Mast)
- Methandrostenolone (Dianabol)
- Oxymethalone (Anadrol) an oral product which stimulates erythropoietin production i.e. the hormone that increases red blood cell production; by increasing red blood cells there is greater transport of oxygen in the body
- Clenbuterol or clen
- Stanazol (Winstrol)
- Clenbuterol is a hormone growth stimulant
- Creatin is a protein supplement generally used alongside steroids
- P3 is a protein supplement
- Liv.52 is a herbal remedy and food supplement that is marketed to prevent liver damage.

Injectable Preparations

- Nandrolone decanoate (Deca Durabolin) an intra muscular injectable
- Testosterone (test) in a range of injectable forms (enanthate, cyprionate or proprionate)
- Sustanon or sust a testosterone product with four different testosterone compounds i.e. long and short chain esters for sustained release over a period of time e.g. weekly injection
- Trenbolone (tren) a relatively fast acting injectable steroid
- Stanazol (Winstrol Depot) an unusual product in that it is available in oral and injectable form

- Human growth hormone (HGH) stimulates cell growth - has anabolic effects but not androgenic effects
- Insulin is an injectable hormone that regulates blood sugar and acts to store blood sugar as glycogen. This is used by some IPED users to increase muscle stores of glycogen. When training, glycogen is broken down into glucose which enables people to train harder
- Metformin is not a steroid but a prescription drug used to regulate blood glucose in type 2 diabetes by stimulating the pancreas to produce insulin.

A range of the above drugs were used by participants. Most used a form of an injectable testosterone with either another injectable form or an oral steroid. Using more than one steroid in this way was quite common. One described his current use:

> "I've recently just finished a course there, I was taking decca test 500 I think it was called, that was an injection and I was cycling that with dianabol tablets, I was taking injections, was doing 2ml a week, and I was taking 5 tablets a day" (245)

A couple of participants described "stacking" when more than one preparation is put into the same syringe for administration.

Whilst there were a few participants who knew the names of all drugs and preparations, and their exact uses very well, there were several who could not really remember the names of drugs and what they were taking.

Patterns of IPED use

Steroids are generally used in 'cycles' during which there will be a period of use of an anabolic steroid use (often injectable and there may also be oral steroids taken) and a period without steroid use to allow the body to recover from the adverse effects. During the 'off' part of the cycle some described using post-cycle therapy (PCT). Post-cycle therapy aims to maintain as much muscle gain as possible as well as encouraging normal hormonal functioning. This include oestrogen inhibitors, oestrogen receptor modulators (e.g. tamoxifen which is a prescription drug used in breast cancer) and human chorionic gonadotrophin (HCG). HCG restores natural testosterone production which returns testes to normal size, increases sperm count and prevents muscle breakdown.

The length of the cycles described by participants varied but several mentioned a five or six week cycle. One long term IPED user describes the intention and typical nature of his cycles:

> "a course of steroids would generally last 12 weeks on, 6 weeks off, 12 weeks on, 6 weeks off. The general consensus is you really should be off for as long as you were on because the damage that it does to your body, i.e. your liver, your kidneys, it takes the same amount of time off to heal that, and then you go again, but people such as myself, felt that we were going to lose muscle gains, and muscle qualities staying off too long, so the obsession is to go quicker and not take the length of time you're really meant to take". (230)

Another described not having a clear cycle due to working patterns:

> "I haven't really got a set routine, because I work away from home quite a lot, it's very hard to get a set cycle going, so it's just when I get the chance really, you know, what I mean, so I could be away for 3 weeks at a time, 4 weeks at a time…..Yeah, so I could be home for a week, 2 weeks, 3 weeks, 4 weeks, so that is my cycle." (236)

There was a theme of participants not sticking to a recommended cycle length. Whilst the above was related to work patterns, another described it as 'laziness':

> "My most recent cycle was probably a bit longer than the average cycle, it was probably about 5 months, which was a good bit longer, I think the average cycle is probably about 3, and it wasn't regimented, it was maybe on for like 3 weeks, just out of probably laziness, probably 3 weeks off, for 1 week forget to do it, another, then another on for 4 weeks, off for 2, so it's no regimented properly… (202)

And another deliberately used a very long 'bulking' time as preparation for a competition:

> "Yeah, I try to, like my last bulk kind of, I decided to compete when I was bulking, and in that bulking, I was going into a prep, and then I ended up like 30 weeks long, which, I know is crazy, but I bounced back super quick, from, I know you say like, like crashing from stuff, I've never had that ever, like I just, like 2 weeks later I'm fine." (203)

Few participants mentioned the names of drugs/preparations used specifically in Post Cycle Therapy (PCT). There was a tendency to talk about PCT in general terms.

Learning Points on Patterns of Drugs Used

- Although there was an awareness of the need to stick to a cycle and the purpose of the cycle, in practice several participants did not follow a cycle.
- The familiarity with the actual drugs used as steroids was reasonable. However there was evidence of less familiarity with the drugs used as part of post cycle therapy.

Adverse effects of IPEDs

Several participants had not experienced any problems, even when probed by the interviewer about the usual and best known side effects. However many did acknowledge they had directly experienced some effects on their mental and physical health. A range of adverse effects were described when asked directly if they had experienced any consequences of their steroid use. The following were mentioned, in order of frequency:

Increased anger, erectile dysfunction, sore and itchy nipples, smaller testes during the 'on' part of the cycle, sleep disturbance, depression and mood swings, liver and kidney damage, increased red blood cell count, reduced immunity, high risk of cancer, insulin-related hypoglycaemia.

Anger was mentioned by several participants.

> "P: I feel myself that I have like noticed kind of like a little bit of aggression, like towards things, like if somebody annoys me, it's not like I wake up in a pure rage like a bull, like, if somebody just annoys me, it's just like I get annoyed quicker.

R: So it's almost like irritability?

P: Yeah, basically, it's just like obviously if you're on it for lengths of time, like just say if you're on it for like 10 weeks, you could wake up pure raging, but it's not came to that yet, and people that's on steroids, it's learning how to control your anger, fair enough, look you're putting something in your body, that is going to physically like mess your head up, but it's being able to control that emotions and control that excess stuff that you've never had before, never felt before, like you need to have the, like willpower to like kind of like not do anything drastic when somebody pisses you off, to be fair." (235)

This 'irritability" and risk of loss of temper was noted by others:

> "I think if you're in the wrong situation it can, it fluctuates your moods, things can tend to irritate you a little bit more, you can snap a lot more, you know, but I think it just depends on the situations that you're in, I think if, you know, if you lived that sort of lifestyle and you're putting yourself in that situation, then you are more prone to it, or if you've got stress, stress on your mind, but I find that if you haven't, it's alright, but it does generally, you know, change your mood." (248)

From both of these participants there was an acknowledgement that increased anger could be dangerous. Although neither actually said it could result in violence, this was implied in the reference to needing to control their mood and avoiding situations where one might get angry. Mood swings were noted by a few participants. One person noted depression during the 'off' cycle and rationalised this as being linked to lack of performance in the gym. This in turn could impact on shortening the off part of the cycle:

> "the negatives to it would be coming off your cycle, I can see why people could get depression, when they come off it, the upside to it, when you're off the cycle is you're, obviously your testosterone levels are a lot lower, you're a lot more mellowed out, things that would maybe get your back up don't, the only thing is you can't operate in the gym, you can't operate physically the same way you would as if you were on it, so it's almost like you're rushing through your PCT, you're rushing through it to get back on your cycle again, …… and their lifestyle isn't the same as somebody like myself who would probably eat and train for a certain thing, I don't think is a good thing" (202)

This participant indicates this is quite a common occurrence. The same participant noted other adverse effects on the immune system, which he considered to be a consequence of not using appropriate post cycle therapy:

> "and several times I've done it as well, there's not been a proper PCT, which has had detrimental effects as well, system crashing very low, to the point of when you get chickenpox, the virus stays in your body for ever, so my immune system crashing so low, I actually broke out in shingles, so a lesson learned, take a proper PCT, so." (202)

Several participants had experienced itchy and/or sore nipples:

> "I've had a weak bit of sore nipples and stuff like that" (241).

This was described as an expected and well known side effect, caused by increased oestrogen:

> "like somebody is putting a needle right through my nipple, and this is, this is an issue called gynecomastia, and what tends to happen is, testosterone aromatises, it's called, which means converts to oestrogen, and this is what's, gynecomastia is- a male developing breasts, now I'm no talking, I'm no talking like 36DD's, I'm talking, they're starting to develop fatty tissue around their nipple, and it's, in the body world, we call it bitch tit's… so I've had occasional pain, I've seen some guys lactating, that bad, but not me" (230)

Shrinking of the testes was also mentioned by a few participants in a similar way, i.e. that it was a known and accepted part of the cycle:

> "well what you notice is, this is, your testicles, your balls they like shrink, shrivel up, whilst you're cycling, that's sort of part of the cycle, but they go back to normal after you stop." (245)

This is a direct androgenic effect of the steroid being used. Another androgenic effect is on libido; reduced libido and erectile dysfunction were mentioned by a couple of participants. Sometimes this was openly volunteered by the participants:

> "It's maybe an age thing but your libido goes down sometimes, a wee bit, depends how you're feeling though" (241)

However this was also acknowledged after gentle probing by the researcher:

> "R: Yeah, what about health problems, have you ever had any physical health problems?
> P: Never.
> R: Because one of the big things I've heard guys talking about during PCT is erectile dysfunction.
> P: Aye, well erectile dysfunction, aye that would probably be the only, but I mean, you expect that, I mean you expect that, that's probably the only thing." (202)

There was an overall sense that some participants either did not want to openly discuss these adverse effects. However it was not always clear if this was because they felt uncomfortable talking about it or because they were reluctant to admit this was a problem.

One participant had a long history of steroid use and had considerable personal experience of adverse effects as well as being aware of issues experienced by other people. One of these issues was a friend with a tumour:

> "he was a friend of mine…. and then he was taking it (human growth hormone) for an injury he had, and he developed a lump on his side one day, just happened to be a lump, and it was cancer, but because he'd been taking growth hormone for his injury, to help his injury, the consultant said to him, we had an 80% chance of healing you, but we've now got a 20% chance of healing you, because the growth hormone, the growth hormone's made it grow, it makes everything grow". (230)

This same participant had personally experienced multiple health problems, many of which are already described. However he had a problem with his blood that had really caused him considerable and prolonged concern:

> "so I get the blood tests back, I've got high red blood cells, massively high red blood cells, a red blood cell count on a male, adult male should be something like 7, mine's was 19, so I'm carrying probably 9 and a half pints of blood rather than 8, my blood pressure is 190/120, it should be 120/80,… (230)

Whilst some of his problems resolved when he stopped taking steroids (liver function, swollen prostate, high cholesterol) the high red blood count persisted:

> "I've now still got high red blood cells, I've now got to go and see a haematologist consultant for my red blood cells, by the time my appointment comes through for that, I've now been off the steroids for 24 weeks, I've since, I've had 2 blood tests at the doctors, and everything was fine except for my red blood cells were staying high, that's why he sent me to the blood doctor, so she does my blood, and a week later, I get a letter from her saying that, you know, when I visited her, she say's it's, it's polycythaemia, which is high red blood cells, but that can develop into polycythaemia vera, polycythaemia vera is blood cancer, and I thought holy f***, here we go again, one to go, so she say's I'm going to take your blood, and I'm 99% sure it's just polycythaemia brought on with steroid abuse, she says, but we'll check it." (230)

One final issue noted by a few participants was sleep disturbance "you would struggle to sleep at night" (245).

This was particularly noted in relation to trenbolone participants:

> "lately, since I've started the trenobol [trenbolone] I do wake up a lot earlier, but I'm wide awake, but I don't see that as a bad thing really, I know some lads who are on it, and they, they're barely sleeping on it, they're like an hour or two a night." (248)

Learning Points on Adverse Effects of IPED use

Experience of some adverse effects is common with the following mentioned:

- feeling irritable and angry
- erectile dysfunction
- sore and itchy nipples
- smaller testes
- depression and mood swings
- sleep disturbance
- reduced libido
- liver and kidney damage
- increased red blood cell count
- reduced immunity
- high risk of cancer

Some IPED users will not openly acknowledge experiencing adverse effects such as erectile dysfunction.

Use of other 'recreational' drugs and alcohol

Approximately half of participants did not take any recreational drugs. For those who had/did use drugs those most frequently mentioned were cocaine and cannabis. Some participants mentioned using cocaine or ecstasy on a night out with friends. It was emphasised these occasions could be few and far between and more because friends were taking the particular drugs:

> " Oh mate it could be like, like I could do it like 3 days in a row, and then not touch it for a year, it could be once a month, like it's just, as, I'm not like a massive recreational user for it, it's like if, it's so situational, if I'm like out with my pals, and that's what they're into, then I'm just like whatever, but I never get like an urge to go and do it, it's just a thing that happens, never, but it's not often, I can't even remember the last time I took any kind of drugs, probably about 3, 4 months ago" (203)

The other recreational drug mentioned was cannabis. Two participants were regular (daily) cannabis smokers. A couple of others had smoked cannabis when younger. One person who had sleep problems took CBD oil:

> "P: No, first sleep I took CBD oil and it fixed it.
> R: Did you think that worked, yeah, so that would be a remedy, so is that something you would share with other people as well?
> P: Yeah, the company was sponsoring me, so, I help, I promote it, I would never promote something that I don't believe in, but I definitely, it did help me unwind when I come home, and I was able to relax and sleep." (229)

Finally one person had used other drugs including Valium for a period of time when he was experiencing relationship problems. He had sought help from a drug counselling service and managed to stop using.

Alcohol was not a big part of the lives of participants with most reporting no use or infrequent use "probably once a month, if that." (248). For some it just did not fit with their lifestyle which centred around the gym and working out:

> "P: Aye, I drink the odd occasion, I don't really drink much.
> R: And does that ever, and is that to do with your lifestyle really in the gym, do you think?
> P: Aye, kind of, it does, it helps you, because if I go out drinking, my motivation for the gym is zero, for about a week, so it does, it sets you back about a week, so that's how, just like that, I'd rather avoid it." (245)

For another participant it was more related to calorie intake and health benefits:

> "…….it's just, I was only having one or two, so it doesn't affect it really, it's just like having a juice, but I just decided to stop it altogether now, because you, you can't do everything, you can't eat all day long and then have that as well, but easier on your stomach as well, so just time to go." (241)

Sources of drugs

IPED were generally sourced on the internet, from friends or from people in the gym but not openly supplied in the gym:

> "P: Every gym, it's rife, yeah, it is, it's just a matter of fact.
> R: Yeah, and is there any, is there, the selling and supply of substances within the gyms, or is it?
> P: No, that'll never happen in the gym." (236)

Harms and Consequences of IPEDs

Injecting related harm

A few participants talked about incidents where injecting had gone wrong and resulted in injecting injuries. On one occasion, a participant punctured a vein:

> "P: and I've had, I've had bleeders, I've had, from actually pulling the needle out, and blood squirting right over the toilet, right, and then it didn't last for long, it squirted, and when it reached its distance, it then started to drop, and then it would run down the back of your leg, and then I'd swab it to stop it, and it's gone, and you know, but this is dangerous, because if that needle has obviously passed through a vein…….
>
> R: An artery or something, yeah.
>
> P: yeah, it's passed through a vein and it's went to the other side of the vein, and as you've pulled it back out, the blood has seeped out, but if the needle had stopped, and unluckily in the centre of the vein and not went right through it, and you injected the oil into that vein, snap, it's over, so it's dangerous." (230)

This participant described how some people mistakenly think you will get better gains if you inject directly into the muscle group you want to build up the most. Certainly a few participants did describe injecting directly into muscles other than the upper outer gluteus (generally considered the safest site to inject). One participant described possible muscle tears and feeling numb after injecting, which suggests the possibility of nerve damage:

> "what I've realised with injecting, like obviously I started panicking, because I've injected into my side now, and I've went and did shoulders and arm, next stage, because I was following a routine, and obviously like I've made an incision in my muscle, in that I've went to the gym and did shoulders, and like I think like, I didn't like rip my side belt, but I like tore my side belt obviously where the incision was, like obviously putting a needle in my muscle, so I've like ripped my side belt or tore it like inside, so obviously I couldn't work shoulders for like 4, 5 days to obviously let that heal, and when you first inject, like you get like, in your side belt or even in your bum, you do get like this numbing sensation, like your arm is away to fall off, or your legs are away to fall off." (235)

Cleanliness was also an issue that needs to be emphasised:

> "I've known a lot of people who have had abscesses, and I've said well, bad, bad administration in terms of cleanliness, because I've never had a problem." (230)

All of these examples highlight the need for information on safe injecting technique to minimise damage and infection.

BBV risk

Overall there was a lack of knowledge regarding BBVs among IPED users, many did not see this was relevant to them. None reported receiving BBV awareness/information from services outwith the specialist clinics. Sharing of injecting equipment was non-existent among the sample, reusing injecting equipment was low and only applied to one user injecting polypeptides three times daily (low frequency of reuse), low levels of STIs were recorded (similar reasons to above - few are tested so STIs may be present but undiagnosed).

Sexual practice

A lot of the younger participants were single. There were several participants across age ranges that did not have an active sex life. Condom use was mentioned when asked but this was not discussed in detail. A couple of participants were married/had partners and used other forms of contraception. Few participants reported having had an STI, however it is worthwhile noting that few had been tested for STIs in the past year. However access to a knowledgeable IPED practitioner could open consultations to enquiry about sexual health and BBVs as establishing trust appears to be a major factor in engaging IPED users.

It was also recognised that libido was affected by drug use and where in the cycle the person currently was. This was noted by a couple of long-term IPED users (see adverse effects), one of whom thought it may be age related:

> "It's maybe an age thing, but your libido goes down sometimes, a wee bit, depends how you're feeling though." (241)

Learning Points on Harms

- Injecting related injuries occurred due to poor injection siting, lack of knowledge about injecting and lack of hygiene.
- There was no evidence of needle sharing.
- There was no evidence that BBV/STI risk, through lack of condom use, was worse than in the general population.

Information Sources and Needs

Sources of information

Overall starting to use IPEDs was a considered decision. In making the decision several participants described how they 'did their homework' to understand what to take and how. People used a range of sources of information about what drugs to use and how to administer them. The internet was the most frequently mentioned source with YouTube being noted by several participants. YouTube videos are available that show people exactly how and where to inject.

> "R: So who did you learn to inject from?
> P: Online tutorial videos.
> R: Was there any one in particular that you used?
> P: Just, I watched a bunch on You Tube, and then I just learned how to do it that way. "(229)

Other sources for more general information were internet searches and online fora that provide advice and information. Older or more experienced gym users might rely on the gym community and peers. This word of mouth was valued:

> "Depends, I'll take something off the internet, it depends if I'm looking for something, if I'm looking for, to find something out, I'll usually just Google it, that would be the first and foremost, but also I'll ask people as well, because it's good to get, like if somebody's like, if you're thinking, well, or want to check something out, then you speak to somebody, oh I had this problem before, then they'll be able to give you maybe a better answer than Google could ever give you, you know what I mean." (245)

However a couple of the more 'experienced' participants also considered themselves to be providing advice to younger IPED users. This advice was based on their personal experience. One participant, who had suffered a huge drop in natural testosterone felt it was important for him to share his learned experience:

> "I've told, some of the people I'm looking after, they should be taking a substance called HCG, Human Chorionic Gonadotropin, it's an extract from pregnant women's urine, it's a hormone that they can sub, sub cue inject, and that helps to keep their natural testosterone levels high, so they should be taking HCG at the start of their course, the middle of their course, the end of the course, and that will keep their natural testosterone levels " (230)

Notably, few used official services such as specialist clinics although some people did have an awareness of these clinics:

> "P: They do, they give you a, they give you a, they've got a, it's like a steroid anonymous, no steroid anonymous, but something like that, it's a, they give you information, it's like every Wednesday you can go to steroid awareness or something like that and you can go, they give you information you know what I mean.
>
> R: That sounds good though, that sounds something useful, but is that something you'd?

> P: Aye, it would be, it would be, yeah, I never went, I never did go, you know what I mean, but it's, it would be useful if you were wanting to find stuff out I would imagine." (245)

A few participants admitted they learned as they gained experience so may have had little information at the start.

Information needs

Participants did not have much to say when asked about information needs or resources they might like. This may be because they felt they had sufficient access to information through their existing sources. However one person did note the need for information at the start of their IPED use. In terms of sources of information, GPs and pharmacies were not considered to be particularly knowledgeable about IPEDs. This included pharmacies that provide needle exchange. Some people mentioned booklets and leaflets on the subject for distribution via these places. In contrast, information received from specialist IPED clinics was greatly valued.

> "P: Yeah, it's great, the guy, the guy is very knowledgeable, he knows what we were talking about, so it's always good, he's dead helpful, he knew exactly what to give in terms of you know, needles and stuff, and he asked, he asked loads of questions, to make sure that he was giving the right, the right stuff, it was, it was great, yourself was great as well, and then obviously you know, yeah it was fine.
>
> R: Yeah, I'm pretty impressed as well, I've been all across Scotland, and I'm, I think he was really, he knows his stuff,… what else do you think they could provide as a service there, that might be helpful to people that use?
>
> P: I think, no he's spot on, I mean, the guy wasn't just giving stuff, he was asking what we, you know, he asked all the questions to be fair, before he was giving you what we needed, and we got a bit of advice off of him and stuff, which was helpful, but I think it's, it's fine, I mean, it is, I've been in some, some of the needle exchanges, they're not very nice places, so." (248)

This interchange demonstrated that there is no problem with a service provider asking pertinent questions – this was understood to be key to gaining the required information to give good advice. This service provider was obviously knowledgeable and demonstrated his knowledge and expertise by asking the right questions.

> "P: If anything, so I always think that when people are going to take stuff no matter what, so instead of telling people not to take it, they should tell them how to take it safely, so if, if there's ever information that's going to go out there, it should be how to tell people to take stuff safely, and make it clear that it's their own choice, and their own decision, but at the end of the day, at least if you're doing it safely, then you're better off than putting yourself at risk, because yeah, so information.
>
> R: What do you think would be the best way to deliver that information, would it be through peers, through leaflets, through websites?
>
> P: I think the best, the best way to learn about that, is the, there should be like a website, you know, because like, so Steroid.com is there like, why is there not an NHS version of that, I mean, I'm sure they could come up with something like that, and then they should probably have some kind of classes as well, that you could go to, if you wanted to learn about that kind of stuff, (203)

A website was noted as a potential way of sharing safer use information. Having the badging of the NHS was considered to be a marker of good quality advice by this participant.

There was also a lack of awareness about specialist IPED clinics evident in some participants.

> "R: See this is, they do do safety advice at the clinics, but it's whether people go to the clinics?
> P: ….yeah, so maybe you need to promote it, promote the clinics more then, because I had no idea there was one that you could go to, that IPED clinic, I'd no idea, until you told me about that." (203)

Imparting information on location of specialist clinics and services was clearly also important. This could be through a website or leaflets/posters.

Services Used

Participant described using online sources to get injecting equipment, a few had used a pharmacy needle exchange but this was unusual. A few had used the specialist need exchange clinic (where some participants were recruited). One participant described this experience:

> "R: Could you give me a wee bit about your experience tonight, and what's it's been like about coming to the clinic?
> P: Sure, a lot of information, I feel as if I've took the majority of it in, to be honest, so J***, when we were walking in the corridor to meet you, the guy in the gym taught me quite a lot but sorry, J***, taught me a lot more in the space of a couple of minutes, than the guy taught me in the gym, a couple of times I've seen him, he's told me the, the effects of not doing it properly, or at least the healthiest way, like in that book you were mentioning, so I'm going to take his advice, because I've got 2 steroids there, I've got deca as well, and J*** is advising me the probably just to test, because you don't know what they both will do you to you at the same time. (201)

There had also been descriptions of services being present in gyms to screen people for BBV and general men's health:

> "I've been tested, aye, I had the life addiction services in the gym, doing men's health and that was checked for your hepatitis and all that stuff." (241)

A few had had to attend their GP for particular problems such as adverse effects including low testosterone levels. Others had encountered problems needing hospital investigations. It was not always clear if that had been related to their steroid use.

Several participants had also used a sexual health clinic for screening. Descriptions for this were fairly matter of fact but a couple of participants felt some embarrassment going to this clinic.
In terms of service needs and developments there was a need for regulation of the steroid market expressed.

> "That's so hard, this is what I mean, this is why I think it should be regulated, because at least they could come somewhere, and know they're buying, you know, because it's up to the

individual, if they want to take or not, you know what I mean, and to, and for them to have to go and buy dodgy stuff from some dodgy website, it, to me it's shocking, you know what I mean, it's not like it's weed or whatever, you know, drugs that you get hooked on, to me, it should be, it should be regulated, 100%, yeah". (236)

Learning Points on Sources of Information

- IPED users generally seek information because they want to be informed.
- The internet and friends/ other gym users are common sources on information.
- Some IPED users said that it would be helpful to have an NHS website providing IPEDs information.
- IPED users rarely use specialist services for information prior to use.
- IPED users are not averse to answering detailed but pertinent questions from knowledgeable staff when visiting an IEP

Service Provider Perspective (Focus Groups)

IPED users were perceived to be less frequent users of BBV and sexual health services compared to other groups. Most were perceived to get their information from YouTube or some other internet source. There was a perception that IPED use was complex due to the chemistry and cycling nature of drug use. As was stated in the Lothian group "The chemistry is complex" suggesting that the staff found it difficult to understand. Interestingly, the terminology in the focus group differed from that used by participants. For example, the term "Blast and Cruise" was used in focus groups but this term was not used by any participants, who instead talked about "cycles". There was a common perception in Glasgow and Lothian that there was an increase in new steroid users in the <25-year-olds who were looking for quick gains. It was considered a risk that large doses of testosterone made people 'more horny' and may result in more unprotected or rougher sex.

In terms of BBV risk this was not considered to be high because IPED users did not share injecting equipment. In Lothian one focus group participant had only tested only 1 person as Hep B positive. Women IPED users were considered very rare but also generally considered to suffer from body dysmorphia.

Over the last year there have been two recorded drug related deaths within the IPED population in Lothian. This was not well understood and further research was needed so that appropriate advice could be provided.

There was a perceived need for more advice on managing testosterone levels and avoiding loss of natural testosterone. This would be helped if there was greater access to endocrinology. There was a need expressed for more psychology support for OCD and body dysmorphia. This group suggested an anonymous clinic would be beneficial for people to use without being concerned about data sharing or worrying about confidentiality. The IPED clinic has limited links with sexual health; it would be

useful to have a specialist sexual health worker based in the clinic, to do more STI testing for example. In terms of training needs there was mention of GPs needing training. Tapping in to lived experience of good harm reduction practices was considered potentially useful. Regular updates/refresher courses were considered useful and face to face training was preferred to online.

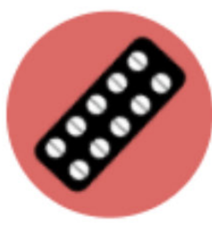
Key Issues on IPED Use

There was a wide range of experience of participants interviewed however both the younger, less experienced participants and the older, long term and very experienced IPED users shared the common goal of wanting to build their physique. Some of the younger users were not fully committed to IPED use and the lifestyle that goes with it, yet. However those who had used more were very committed to the scene. Very controlled behaviour is required for the training and diet that goes along with the gym and IPED use scene. This was demonstrated by the minimal engagement in using other drugs or alcohol, often because it interfered with training ability.

The other side of this controlled behaviour is that SHBBV risk behaviour is also minimised. Awareness of sexual risk-taking behaviour was not particularly apparent. The main risks, from the IPED users point of view, are the adverse effects of the drugs in the short term (e.g. anger, sleep disturbance etc.) and the longer term (erectile dysfunction, liver toxicity etc). The lack of understanding of these effects and how to avoid or minimise impact should be the focus of service providers' responses. A quick internet search revealed that many of the sources of information are suppliers of products so there is a lack of easily accessible non-commercial, unbiased advice. Providing hormone testing would facilitate appropriate advice being given. The occurrence of injecting injuries also highlighted a need for more information on safer injecting techniques. Service providers should not assume IPED users know what they are doing when injecting as they may well be following inappropriate advice.

Sexual risk-taking behaviours among the sample seem to be consistent with demographic profiles generally. For example, young single men and women are at higher risk of exposure to STIs than older people in monogamous relationships. Although low risk-taking behaviours may lead to the proposition that specialist STI/BBV services are not necessary for IPED users, the data suggests something else. The specialist clinics provide exactly what the user wants: hormone tests, advice on safe cycle usage, preventative measures to reduce the risk of harm, clean injecting equipment and safe injecting advice. If such services can be provided then adjacent BBV and STI clinics could be incorporated into them.

Transactional Sex



Selling or exchanging sex for money or other goods

"It was my partner I was with, he would inject me and what a mess he would make of me."

Participants Involved in Transactional Sex

Fifteen women and one man were interviewed in relation to transactional sex. Eight identified as heterosexual, seven considered themselves bisexual and one as a gay man. The age range was 24-51 years. The majority were Scottish with one person Eastern European. The self- identity of women, and the terminology they used, was interesting because participants seemed a bit surprised to be asked. They needed some prompting with suggestions. They generally settled on the following: working girl, escort and prostitute. The most frequent term used for men was 'punters' but 'client' was also used.

The participants worked in a range of settings including working the streets, via brothels, escort agencies, saunas or online via direct personal accounts. The number of customers seen in a working time period also varied considerably from 1 or 2 clients a day (and not every day) up to 12 a day. Some participants worked for a few days every week whilst one noted working 2 or 3 times a month.

The strongest theme emerging across all participant interviews was that of vulnerability. Some were vulnerable because they were young when first introduced to drugs and/or transactional sex. Some had challenging early life circumstances including violent homes and being taken into the care system. This increased their exposure to people who would take advantage of their vulnerabilities as well as to other women and girls who were already involved in transactional sex. This issue of vulnerability is evident across the themes discussed below.

Note that when quotes are used in this section R refers to the researcher and P to the participant.

Drugs Used

There was a broad range of drugs used and poly-drug use was commonly described. Many participants started their drug use with heroin, often not knowing exactly what they were using. Drugs, and alcohol, could be used to make it easier to take part in sexual acts and to block out feelings of shame:

> "For my first time, what it was, right, is they told me obviously about heroin, and that, and I was a wee bit obviously wary, and plus they were telling me that I had a client and that coming, she was there obviously in the same house at that time, so I was a wee bit nervous and that, scared, a bit dirty, I think then, so she said here, take this, this will make, calm you down and that, and it did, you know, after I was, I did the deed, I did feel dirty and that, and then that kind of got me into the situation that I needed the drugs to obviously get me out in that zone" (326)

High risk poly drug use was described by some participants:

> "Yeah, I use coke, crack, I use heroin, Valium, gabapentin, anything, I like to be out of my face, when I'm in that mood." (326)

> "R: So let's focus on drug use then, so what drugs do you take?
> P: Crack cocaine, heroin occasionally, zanax, I'm prescribed methadone, chlorpromazine, which is Largactil, diazepam and pregabalin, so that's it". (327)

High risk use was also evident in terms of the amount of drugs people would take:

> "P: Vallies, god I could take 20, 30 in the one day I would say.
> R: 10mgs?
> P: Aye, aye, you get them, I get them in a strip, so it's the real McCoy, sometimes you get the white ones, which aren't actually Valium, they're antipsychotics and I can remember one time I had, I was with a client, and I was pure out of it, and honestly I couldn't remember a thing, I don't know what he done or he could have done anything to me." (326)

Other participants had strong preferences for drugs while others expressed specific dislikes for certain drugs including benzodiazepines, gabapentin and pregabalin. One participant described using ketamine and it was an unpleasant experience including memory loss and black outs:

> "Oh yeah, I did not like that, he had ketamine in the house, and he used to get it from this girl, and I tried, I tried some of it, and I'd been awake for a few days, and I, it was like a, I had blackouts, I don't know what happened, I don't, I mean I know I was there, I know I wasn't passed out or anything, but it's just like pure gaps, and I wasn't really drinking or anything, so it was really bizarre, they just blocked out my memory, and I know that there was nothing really that happened, it was just the two of them chatting, but that was not a nice experience, too trippy, too mad." (324)

Crack cocaine use was described as becoming more popular and several participants described smoking crack cocaine:

> "R: No, see the, but just back to the crack thing that I forgot to, because we said £350 worth, is the crack thing been fairly new for you?
> P: Yeah, in the last 5 years, yeah.
> R: And is it everywhere?
> P: Yeah, it's so prevalent now it's overtaken smack, definitely." (327)

Initiation in crack use came from a range of people including clients as this participant described:

> "Yeah, I was like no, no, you're alright, I'll just snort it, and I was, I was snorting it and everything, but I did have a few draws, like I did try it, I was like let me see what that's all about, and I didn't feel anything, and I was like, oh it doesn't work, it's a load of, it's a load of shite, and me and this guy, like we just had this great chemistry, it was just everything that I wanted, he was everything I bloody wanted, right, and I never stopped to realise, I never stopped to question that the first couple of times we'd met, he just stayed really quiet, he was studying me, he was studying me, right, so he then became everything I wanted, because he'd been studying me, I didn't see that, I was being manipulated, my god he was good, he was good, and then he, he said right, you're not smoking this thing properly, this is, you've got to breathe it in, and then hold it in, and Jesus, my god, I have never felt anything so amazing my life……..………and that's when I knew, right, I, I need to marry this man, I want to smoke this stuff every day……….".(324)

Sharing of crack pipes was mentioned, when asked, by a couple of participants and will be considered under risk behaviour.

Street benzodiazepines, Xanax and Valium, also described as benzos, were very common and very cheap, leading to high levels of use. This participant described how someone was giving them to her free:

> “R ..so see in terms of Valium, so that’s been a wee while, but how many would you take?
> P: Well they were, they were getting posted through my door, so I wasn’t even having to pay for them, and I’m like, oh no, here we go, but I don’t, because of my size and build, it doesn’t take a lot, but you get what, 15 for a tenner or something, and that would, I wouldn’t be able to remember for days..” (344)

Use of benzodiazepines was described in terms of self-medicating for insomnia and to help withdrawals from opiates. One person described trying to get a prescription for nitrazepam but not being able:

> “..and the f****** drug team sent a note to them saying do not give her any benzos’, so in the end I was then having to buy Xanax off-line, online, you know what I mean.” (333)

Regarding heroin use, most but not all participants (one person had a codeine dependence) used heroin at some point in their life. A few were on a methadone prescription at the time of interview and not using heroin on top. A few people described smoking heroin and not injecting. However there was widespread experience of heroin injecting across the group. Initiation into injecting was usually described as being facilitated by other people including boyfriends, friends and people involved in transactional sex.

> “.. it was one of my, my friends, they, it was one of their contacts, she gave me the heroin, she was in the same house, and they seen I was really nervous, she obviously made up the kit, that was heroin, and gave me it, injected me, because I didn’t have a scooby what to do, and then the guy come in, we went to the room, and just got on with it. “(326)

People who initiated injecting were not necessarily skilled as described below:

> “It was a partner I was with, he would inject me and what a mess he would make of me, looking back, I think oh my god, but that’s how I won’t inject anyone, because somebody was at my house no[t] that long ago asking me, and I thought no.” (344)

Indeed scarring from long term drug use was described by a number of participants and one participant had a serious injecting injury to her arm.

> “R: And see the, and obviously when we’re talking about the risks, this probably falls into this, you’ve got an injury at the moment, haven’t you, from that, do you, what about sharing equipment and stuff like that?
> P: I did have once, and I was with my ex-partner, but not anymore.” (325)

The risks of needle sharing are explored further under Risk Behaviour and Blood Borne Viruses.

Learning Points on Drugs Used

- A range of drug are used and taken in a range of ways.
- Drugs/alcohol are used to make it easier to have sex and to block out feelings of shame.
- Women were often introduced to drugs by someone usually with some sort of power over them or someone who was more experienced in drug use.
- High risk drug use is evident in terms of:
  - Polydrug use
  - Consuming large numbers of tablets (presumed to be benzodiazepines)
  - Sharing crack pipes/injecting equipment
  - Lack of awareness of safe injecting practice

First Experience of Transactional Sex

All women were asked about their first experience of transactional sex. The age at which this took place was very variable from 14 years (one person who had been in care) to 34 years.

Some had been groomed for example the 14-year-old whose 'boyfriend' was 24 years old and manipulated her into drug use as a means of controlling her, then led her into selling sex for money for drugs:

> "I was in care, and my boyfriend was 24, and he basically pimped me out, so and got me onto heroin, by telling me it was cocaine, and gave me it for 6 months, then told me what it was, and I was addicted to it by that point, so I had no [choice] to take it, and then he started pimping me out basically." (327)

Another participant had also been 'groomed' by an older man she met through a Recovery Hub:

> "and I just couldn't work, and it dropped my studies as well, so just everything, everything went, and it was one guy who was okay to help me, oh and I met one older guy from the R******* Hub, but because he was from R******** Hub, I thought he's very nice, he was very nice person, he was 50 years old, but after he started to buy me presents, clothes, I never, but with him I never asked for his help, but with him it was really, I didn't want to use even, he, somehow, but he was buying me food, when I finally found hostel, he was knocking my door, like too much, I don't know, I was a little bit scared and then he started to touch me as well, but because he was older, with him it ended up with police and I didn't call, because nurses saw how he was hugging me sometimes.." (346)

Grooming comes from those who prey on the vulnerability of women. However other people found themselves involved from a place of vulnerability which included desperation for money, not wanting to be caught shoplifting or selling drugs as they might end up in prison and they rationalised

that selling sex was preferable. Other vulnerabilities came from being made homeless or having benefits stopped:

> "my benefits had been stopped as well, I was on Universal Credit, so I had no money for 8 weeks and that's kind of how I got into doing it" (344)

One participant described the women's hostel she lived in whilst homeless regularly attracted men looking for sex.

> "R: Yeah, because it used to be quite notorious for guys just coming in, driving, ringing the phone?
> P: Aye, the phone box.
> R: So would that happen quite regularly, when you were staying there?
> P: Yeah.
> R: All the time?
> P: Yeah, it was bad.
> R: It was quite notorious, so the resident that introduced you, or took you for the first time, had she been a working girl and she knew what she was doing?
> P: Ah ha.
> R: And was she quite older or?
> P: She was round about, I'm sure she was round about the same age as me, aye.
> R: And at that time, was it the, was it using *** Street as the base or would you come to this area?
> P: No, it was here she brought me, aye, because it was still the old *** Bus station, at the time." (334)

A couple of participants described bereavement and mental health as being key factors in their involvement in transactional sex:

> "R: So are you okay with me asking you the question about the first time you sold sex, how old were you?
> P: I was 24.
> R: 24, and what was happening at your life at that time that led you there?
> P: I lost my partner.
> R: Right, and was that through drug death or?
> P: Aye.
> R: And what happened as a result of that then?
> P: I just gave up." (326)

> "P: I would have been about 34, I think.
> R: What was happening in your life at that moment?
> P: My, I had post-natal depression, and post-natal psychosis, or whatever it's called, and my, oh loads of shit happened, and my daughter ended up going to stay with her dad and I'd been off it for 13 years, and I, I packed a bag and buggered off to G******, and ended up meeting a lassie, and got introduced to A********.
> R: And did she set up the site for you and stuff like that, or did she just show you how to?
> P: She just showed me how, and I did it, I took it from there myself." (323)

A few participants started to work through escort agencies or brothels. One participant described being interviewed by the women who ran an agency:

> "P: …….******** Escort Agency, I don't know if they're still around.
> R: Oh right, was she in the yellow pages as well?
> P: She was, and she's this lovely woman, she's a lovely polite well-spoken little woman, and we met in town, and she wanted to just, she wanted to speak to me and see me, and discuss how she runs her business, told me about how she, how long she's been around ……, she was, she was really sweet, and she was like, now I know you are quite young [17yrs], you're quite, you're younger than what I usually take on, an do you, you're grown up enough to know what's involved in the job, don't you, she didn't come out and say what it was, but she's like you know what's involved, you know, and she would get me work, like she would phone me and I would give her £60, the guy would pay £170, I'd get £110, she'd get £60, for arranging the booking and things, and it was quite safe, because you know, she would know the people." (324)

Several participants described their shame after the first time they were involved in transactional sex, others described blocking out the experience as a way of coping.

> "R: Right, and how did it feel like that first time?
> P: Dreadful, the first punter, I got into a hackney, went right home to *** Street, and greet" (334)

Learning Points on getting involved in Transactional Sex

- Times of trauma, whether due to poor mental health, loss of a partner, being made homeless and losing benefits are key points when women who use drugs consider involvement in transactional sex.
- Vulnerability in women, whether due to being in the care system and not having adequate support, or having older boyfriends who may have groomed them, or boyfriends who use drugs, is key to involvement in transactional sex.
- A conscious decision is sometimes made around how to make money and transactional sex can be chosen over other illegal activities.

Harms

BBV risk from injecting behaviour

Participants were specifically asked about sharing of equipment during drug use. All of those who had or were currently still injecting said they had shared injecting equipment in the past. None referred to recent injecting and this might reflect their generally older age and long history of drug use but might also be that they did not want to admit to this. There was clearly an understanding that sharing equipment put them at risk of blood borne virus transmission.

At least five participants had had hepatitis C, and one participant had had hepatitis B, all from sharing injecting equipment. Sharing was generally done in the context of a partner relationship:

> "I have had to share with my partner in the past aye, but I always try and make sure that I've got enough." (334)

But also with other drug using acquaintances, particularly when 'desperate':

> "I have done that in the past, aye, I've used other people's pins, I've used pots, I've been desperate and shared, so there is a chance of having hep C there, aye, I need to get tested again, I think actually, because I'm not sure if I've got it or not, you know how your antibodies fight it and all that." (344)

Sharing other equipment was also uncovered during discussions:

> "P: Aye, I've got Hep.
> R: ……., you reckon that was from sharing with your partner, because he had it?
> P: It was, because he had it, I didn't know he had it, he never told me, so.
> R: And did you share water and spoons and filters anyway?
> P: Ah ha.
> R: And so it's just like, so you were sharing that?
> P: So I shared it with him, and that was it." (325)

Injecting harm

A few participants described having injecting injuries such as abscesses, collapsed veins and other infections.

> "R: Okay, so see when you were injecting the legal highs, did you always use your own needles?
> P: No, I was using a lot of old equipment and I didn't know where to get, and I was ordering online, but I had a few of syringes, and I, I have scars on my hands now, and my veins are really bad.
> R: From where the needles like, from overusing?
> P: Yes, yes, I used a lot of times where, and a couple of times I had infections as well, and yeah, I just don't have veins anymore, I was having blood, I was having blood test today, and it was special nurse." (346)

In the case of this women there may have been added risk from injecting legal highs. People who started using legal highs might not have been as readily aware of sources of equipment.

Sharing of crack pipes was described by a couple of participants. Not because they shared themselves but because they had seen the consequences:

> "P: They share pipes.
> R: ……yeah, what……
> P: They've all got scabs all over them.
> R: ………oh have they, right.
> R: Aye, they've all got scabs all over their face and aye, so it's horrible." (325)

In this case there may have been a skin infection associated with pipe sharing.

Sexual health harms

Participants were asked about their use of condoms and contraception and testing for sexually transmitted infections through sexual health check ups. Most said they used condoms but not with every client and not all of the time; some clients might say they were allergic to latex.

One particularly candid participant openly revealed incidences of rape in relation to condom use:

> "R: Thanks for sharing that, so did you, do you always practice safe sex?
> P: No, not always, no.
> R: Was that an agreement you came with, with people, or was that just, was that like?
> P: No, there was a couple of times I was raped, and my first experience was in a sauna and the man raped me anally, and that was really quite a hard experience to go through, but normally, what was the question again?
> R: It was about safe sex, about condom use really.
> P: No, I don't, I don't always use a condom, because they'll sometimes ask you, oh I'll pay a bit extra if you don't use a condom, and then I'll judge it by how they are, their appearance and stuff like that, and then just to get my drugs, I would go for it, you know what I mean, and it was more money for drugs." (327)

This participant was also very open in sharing that she would sometimes forgo condom use to be paid extra. The money being used to buy drugs.

There will be considerable barriers to break down with some people involved in transactional sex. As the following interaction reveals the willingness to share sensitive information would only be done if they felt comfortable with the person who was asking.

> "R: And when were you last tested; do you know?
> P: Let me think now, probably about a year ago, do you mean for sexual health?
> R: Yeah.
> P: Yeah, about a year ago, yeah.
> R: And did you feel, did you feel comfortable speaking to them about what, like did you tell them what you?
> P: No, no.

R: And do you think you ever would?
P: No, probably not.
R: No, and do you think you'd ever, like I know you've told me, and I'm so grateful for that, but I also, I wonder what it would take to speak to other people about it, or, do you know what, maybe what it is, that makes it easy to speak to people?
P: Em……..
R: Because even your drug use, it's different.
P: ………I'm not sure on that one, I couldn't say, it would depend on the person as well, I suppose." (323)

The importance of a friendly and non-judgemental person was not developed further in this interview but was raised in other interviews and is considered further under service needs.

Whilst there was some baseline knowledge about the importance of condom use to protect against HIV, hepatitis C and unwanted pregnancy, there seemed to be less understanding of the need to have regular smear tests as well as being tested for other STIs:

"R: In terms of sexual transmitted infections that you've checked and you're clear, do you know about the different sexual transmitted infections, like chlamydia, you heard of these?
P: Kind of.
R: There's also gonorrhoea.
P: I've heard of it, but.
R: You've heard of it, but you don't know.
P: Not really." (346)

"R: No, ever get smear test done?
P: Aye, I've got, only had so many smear tests in my full life, I'm bad for no going to them, aye.
R: So is there any reason in particular that you don't go and get sexual health testing done?
P: No, I just don't feel I would have a reason to.
R: Okay, and that would even be when you were a working girl and?
P: Aye, because it would be different if a condom split or something, aye it would.
R: And did you ever find, that a condom ever?
P: Aye, actually I just remember that happened once and I went and got tested….." (334)

Learning Points on Harms

- Participants knew the risks around sharing injecting equipment and pipes and although they had shared in the past, they said they had not shared recently.
- There was often some vagueness when asked if and when they had had a sexual health check-up.
- If someone attends for a check-up it can be indicative of other potential factors, e.g. attendance for a sexual health check-up might be triggered by unprotected sex of a traumatic nature thus trauma awareness for service providers is essential.
- Women involved in transactional sex may have low knowledge or understanding of the full range of STIs and the symptoms and long-term effects of these.
- Women involved in transactional sex may be unlikely to attend for regular smear tests.

Information Needs

One participant differed in her route into drug use from others as she became dependent on opiate containing analgesics (painkillers). This participant had paracetamol poisoning because she was taking combination medications of codeine and paracetamol and was unaware of the paracetamol toxicity. She would have benefitted from early involvement or interaction at a community pharmacy level where she was buying medicines.

There was a need for information on the effects of certain drugs. As well as paracetamol toxicity (as mentioned above) there was evidence of a need for information on cocaine and the effects on the heart:

" I asked about cocaine, because I feel that my heart is weird, I was scared and I was told that its better never to inject cocaine, I was not doing that after, because yeah, I was told its better not to, even small amounts" (346)

There was a clear desire for information on drugs expressed by a few participants. The internet was used by some as a source of information. One participant described this in the following way:
" …when I try a drug, right, I get quite obsessed about it, I want to know all about it, I want to know its story, it's like I want to intimately become, meet it… ..Yeah like I study it, how does it work and so the Seroquel you know, I looked it up and I was like, did you know that this was used recreationally in like the big parties in LS and things, and they called them Susie Qs." (324)

Information on good injecting practice was also needed by many. Several participants had relied entirely on the skills of another person, either a friend or partner, to inject them, at least initially.
" It was a partner I was with, he would inject me and what a mess he would make of me. Looking back I think 'oh my god', but that's why I won't inject anyone because somebody was at my house no that long ago asking me [to inject for them] and I thought no." (344)

For this particular participant there were considerable adverse consequences of poor injecting technique as she ended up in hospital with a severe wound infection. Some used pharmacists for information picking up the leaflets that might be available. One person mentioned that information about safe injecting and drug taking often came from the older women involved in transactional sex. Several participants referred to the need for information on how to manage behavioural issues in others. Some people were aware of their vulnerabilities, or those in other similar positions. One referred to receiving unwanted attention from an older man but not knowing how to manage this. Another was aware of a girl who was struggling to get out of a dangerous and abusive group of people:

> "but I think she'd fell in, she'd be, she'd fell into a gang down there, and she was, I think she was gang raped by them and they were threatening her, that she couldn't tell anyone, and she didn't trust anyone, they were telling her that she knew the, they knew people in the police and stuff, and she had went to U***********, and they were, they were able to find her somewhere to stay, like one of the girls let her stay with them.." (324)

Learning Points on Information Needs

Several information needs were identified:

- Drug information including effects
- Safe injecting practice
- Managing difficult behaviour in others including clients who might take advantage of the women's vulnerabilities
- Sexual health information including testing for STIs and BBVs, condom use, smear tests

Service Needs

The importance of a relationship with staff in services was mentioned by several participants. Changes in staff could undermine the development of a meaningful, therapeutic relationship.

> "and the thing is you get a new worker every 2 weeks, right, so you get no, you never get any connection with any of them whatsoever, because you go in, there's somebody new, you know what I mean, always somebody new, so how are you meant to build a relationship with them" (333)

When asked specifically to describe the most important thing about training staff to work with people involved in transactional sex, this participant expanded on the importance of maintaining reliable, meaningful relationships:

> "Do you know what, listen, and do what you do, what you say you're going to do, it's two so simple things, right, and keep in touch with the person, don't just say you're going to do something and then the person never hears from you again, because they lose, then they lose

> trust in everybody, do you know what I mean, the only people we don't want to lose trust with is this lot, because they do what they say they're going to do, so that, that would be my main, main thing, is if you promise a woman, you're going to do something, you do it, and you do it the next day, or as soon as you can, but you give them a timescale" (333)

The importance of feeling listened to, in a non-judgemental manner was repeatedly highlighted:

> "Yeah, well I was just saying that this is actually the first time that I feel like they have listened to me, because I told them that I, I only wanted 30ml, I was only using, using a tenner bag a day, and I thought 30ml would cover it, and the worker is actually listening to me this time, so I feel like I'm a bit more in control about it, so that, that helps." (344)

By being listened to this participant developed a trusting relationship with her nurse prescriber. Meaningful relationships were remembered over long periods of time, perhaps because they were few and far between. One participant recalls a past drugs worker and a psychiatrist with fondness:

> "P: Aye, 20 years ago, when I lived in L********, I went, I had a beautiful woman called J*****, who came from A*******, her and a psychiatrist called Dr *********, worked in the L******* one, and they were absolutely brilliant, so they were.
> R: And what made them good?
> P: They never forgot about me, right, she was there when I had my wain, for god sake, she came up the next day with big, the biggest bouquet of flowers from everybody in the centre, because I'm one of them." (333)

One participant had experience of a peer led service and particularly valued the lack of rules.

> "P: well I'll tell you what, see ****, see because it was peer, peer led, you got to see a lot of, it was quite dysfunctional at some points, right, and it was really good, because it was so real, because it, because it, there wasn't that thing about, you know, professionals and……….
> R: Order, no order, yeah, nice.
> P: ……….and rules, and laws and stuff." (324)

It was also highlighted that women involved in transactional sex often work all night or late into the night and so attending appointments early in the day was very difficult and later appointments or open clinics were noted as possible solutions.

Learning Points on Service Needs

- Sources of general advice and help
- Continuity of staff
- Staff in services listen to women and do what they say they will
- Trusting, non-judgemental, trauma aware relationships, with an understanding around the need to sell sex,
- Services that open late or have flexibility around appointment times

Service Provider Perspective (Focus Groups)

Service providers indicated that there was a much larger and more hidden population than we know.

Three different groups with different needs were proposed:

1. Those involved in on street working are usually an older and more vulnerable population with large amounts of poly drug use.
2. Those who sell sex within saunas are usually a more varied group in terms of vulnerability and age.
3. Those who sell online are an even more varied group.

There were both men and women involved in transactional sex, as noted in Fife.

There were several online sites used by women that service providers mentioned: Vivastreet (often Eastern European girls working from flats), Adultworks and Craigslist were also mentioned.

Across groups it seemed there were young women involved in transactional sex, many of whom were not in addiction treatment but were considered high risk and particularly vulnerable. This group attended services to get HIV tests to prove they were HIV negative (Fife). It was suggested (Lothian) that young women might have more chaotic drug use and could not access ORT. This left them more vulnerable.

Motivations for drug use were reported to include coping with transactional sex. For others, transactional sex gave them money for drugs. Risk taking behaviour, in particular not using condoms, was recognised. Some men would pay more for condomless sex.

Across focus groups there was mention of people returning to sex work or getting involved in transactional sex because of financial pressure. Sanctions and changeovers between benefits had left some people without money. Some would say they needed to feed their children.

There were some clear gaps in service provision, e.g. out of hours, trauma informed care generally and psychological assistance to help with more deep-rooted trauma.

The staff training needs identified included communication skills such as confidence in asking appropriate questions around involvement in transactional sex. There was a recognition that women wanted and needed to be treated as valued human beings. This was seen as very important for building trusting relationships. The importance of identifying and supporting vicarious trauma was also raised.

Key Issues on Transactional Sex

Involvement in transactional sex increased vulnerability to rape and sexual assault and in fact some degree of trauma was widespread amongst all the respondents. This trauma also included the loss of a partner. Trauma was deeply rooted in childhood experiences of abuse by siblings, parents and other family members. Many of the women interviewed had been raped – some multiple times. The lack of meaningful relationships in people's lives was notable. There was also considerable shame associated with transactional sex. The sum of all of these very challenging issues is that women involved in transactional sex can be distrustful and harder to engage than other service users.

For service providers it might take time to build relationships. The need for information was evident to protect women from drug related harm and injecting injuries as well as transmission of BBVs and other sexually transmitted infections. Building relationships on these relatively simple information sharing grounds may pave the way to address the more challenging underlying issues around shame, trauma and abuse.

Conclusions and Key Issues

Access to the Target Groups

This research focussed on specific and distinct groups that need to be considered in service provision within BBV and harm reduction services. Access to these groups was variable and is indicative of how easy it might or might not be to engage or reach out to them to provide appropriate support. It was relatively easy to make contact with women involved in transactional sex. This group often uses other services such as harm reduction services and counselling support, as well as being on ORT so will be known to service providers, however they are unlikely to disclose their involvement in transactional sex. IPED users were a bit more challenging to engage with but it was easier to make contact with them through gyms. They rarely seek health or other services unless they have a specific health problem, however they often display identifiable side effects, especially within the longer-term users. This raises the importance of awareness in generalist health providers which will be considered further shortly. MSM who are involved in chemsex were the most difficult to identify and recruit for the research. This group are deliberately secretive and are not generally visible or identifiable. This poses challenges for engagement with services and providing appropriate support. However many MSM will seek sexual health checks and BBV testing so this seems like an obvious focus for developing relationships which are perhaps easier to develop than with the other two groups.

Key Issues

All of the key Issues highlighted throughout the report for consideration are brought together here.

Chemsex

Drugs Used

- Mephedrone can be painful to snort due to crystalline formulation.
- Potent drugs like GHB require careful dosing and accurate measurement of small volumes. It would be worth considering how this could be made 'safer'.
- Poly substance use is common and certain combinations may raise particular risks e.g. GHB and ketamine both have strong dissociative effects that might make people take more risks than they otherwise would and raises issues of consent for sexual activity.
- Other drugs such as cocaine and MDMA may be considered as chems by some and their role in widening drug use to the more traditional chems or in sexualised drug use generally may be a target area for early interventions.
- There is a lack of awareness of safe and appropriate dosing.
- Rational decision making is adversely affected by the effects of the drug and the length of time people use drugs in a 'session'.
- Guidance of how much is 'safe' (with all the usual caveats on unknown purity and content for illegal substances) for each administration and over a period of time is required.

Sexual Practice and the Nature of Chemsex

- Motivations include maximising sexual pleasure, overcoming inhibitions, increasing confidence and coping with mental health issues. Identifying and understanding these motivations are important for assessing potential harms (if any) and identifying the most appropriate education and treatment options.
- The association between drug use and pleasurable sex is very powerful. Some people may need help in dissociating the two (if they want to). Interventions which focus on pleasurable sober sex may be useful for people experiencing compulsive chemsex patterns.
- Chemsex sessions can last extended periods of time (up to several days). This could have a detrimental impact on physical and mental health and wellbeing.

Risk Behaviour

- Perception of risk within the chemsex community may differ greatly from perception of risk by people supporting clients in services. Some form of sexual risk taking appears to be relatively common.
- Excessive risk taking may be part of self-destructive behaviours linked to shame and stigma and requiring more in-depth support or counselling.
- PrEP may have influenced people's perception of risk and may have resulted in lower condom use.
- People make irrational assumptions that other people do not take risks and that their STI and BBV status is known by their sexual partners, whilst taking considerable risks themselves by not using condoms.
- The message that PrEP only protects against HIV and does not protect against other infections continues to be important.
- It is important for services to continue to stress condom use as the only way to protect against other STIs and BBVs.
- Familiarity by those working in sexual health services with dosing schedules of PrEP, for different patterns of use, is needed to ensure it is being appropriately used.
- Adherence to PrEP or ARV medications could become challenging if individuals experience chaotic patterns of use with drugs and may lead people to believe they have a greater level of protection from acquiring or transmitting HIV than is actually the case.

Harms and Consequences

Commonly experienced harms that people should be warned of were:

i. paranoia
ii. anxiety
iii. mental and physical exhaustion
iv. feelings of shame or disgust towards oneself
v. financial issues
vi. impact on work

Knowledge of sources of help in coping with these effects is required.

Information Needs

- Practical drug information including dosage advice and information on overdose is importan.
- Knowledge on the existing information sources is limited.
- The terminology used needs some careful consideration to ensure an awareness of glamorising language (e.g. slamming for injecting, chems for drugs).
- Keep information factual.
- Consider novel delivery of information e.g. films, podcasts, animations etc.
- Role of peers in education in assertive outreach could be further explored.

Services

- Data protection concerns can prevent people accessing services and treatment. Explaining the rationale for asking certain assessment questions and normalising this may be an important part in reassuring clients to disclose information.
- People obtaining clean injecting equipment for chemsex based drug use may be particularly sensitive to anything that could be interpreted as 'negative' treatment or judgment. Staff need to be very sensitive to this.
  Staff must be aware of potential embarrassment, shame and fear of judgement.
- Consideration of how questions are asked about chemsex, use of language and informing clients of the reasons why the questions are asked is useful to overcome barriers to disclosure.
- Staff should be alert to potential paranoia as a side effect of the types of drugs used. This can influence client behaviour and perceptions of staff behaviour.

IPEDs Key Points

Nature of drug use

- Although there was an awareness of the need to use a cycle and the purpose of the cycle, in practice this was not followed by several participants.
- The familiarity with the actual drugs used as steroids was reasonable. However there was evidence of less familiarity with the drugs used as part of post cycle therapy.

Experience of some adverse effects is common, although some IPED users will not openly acknowledge experiencing adverse effects, with the following mentioned:

i. feeling angry
ii. erectile dysfunction
iii. sore and itchy nipples
iv. smaller testes
v. sleep disturbance, depression and mood swings
vi. liver and kidney damage
vii. increased red blood cell count
viii. reduced immunity
ix. high risk of cancer

Harms

- Injecting related injuries did occur due to poor injection siting and lack of hygiene.
- There was no evidence of needle sharing.
- There was no evidence that BBV risk through lack of condom use was worse than in the general population.

Information sources

- IPED users generally seek information because they want to be informed.
- The internet and friends/ other gym users are common sources of information.
- IPED users rarely use specialist services for information prior to use.

Transactional Sex Key Points

Drug Use

- A range of drug are used and taken in a range of ways.
- Drugs/alcohol are used to make it easier to have sex and to block out feelings of shame
- Women were often introduced to drugs by someone usually with some sort of power over them or someone who was more experienced in drug use.

High risk drug use is evident in terms of:

i. Consuming large numbers of tablets (presumed to be benzodiazepines)
ii. Sharing crack pipes
iii. Lack of awareness of safe injecting practice
iv. Polydrug use

Trauma and Vulnerability

- Times of trauma, whether due to poor mental health, loss of a partner, being made homeless and losing benefits are key points when women who use drugs consider involvement in transactional sex.
- Vulnerability in women, whether due to being in the care system and not having adequate support, or having older boyfriends who may have groomed them, or boyfriends who use drugs is key to involvement in transactional sex.

Sexual Health

- There was often some vagueness when asked if and when they had had a sexual health check-up indicating attendance for sexual health checks was haphazard.
- If someone actually goes for a check-up it is indicative of other potential factors, e.g. attendance for a sexual health check-up might be triggered by unprotected sex of a traumatic nature thus

trauma awareness is essential for service providers is essential.
- Women involved in transactional sex may have low knowledge or understanding of the full range of STIs and the symptoms and long-term effects of these.
- Women involved in transactional sex may be unlikely to attend for regular smear tests.

Service and Information Needs

i. Drug information including effects and adverse effects
ii. Safe injecting practice
iii. Managing difficult behaviour in others including clients who might take advantage of the women's vulnerabilities
iv. Sexual health information including testing for STIs and BBVs, condom use, smear tests
v. Sources of advice and help
vi. Continuity of staff
vii. Staff in services who listen to women and follow through with their agreed tasks
viii. Trusting, non-judgemental, trauma aware relationships, with an understanding around the need to sell sex
ix. Services that open late or have flexibility around appointment times

Service Response

Many service providers who participated in focus groups seemed well informed of the issues facing these different groups. However one area where knowledge was limited was in the familiarity with the range and nature of drugs, particularly IPEDs. There were a couple of exceptions of service providers who are immersed in providing specialised advice on this topic. These specialist IPED clinics and the staff who provide these services were held in high regard by those who had used them. IPED users are not necessarily at greater risk of BBV and sexual health harm than the general population, however they are at risk of harm from adverse effects of the drugs used and injecting related harm through poor technique.

Women involved in transactional sex are often vulnerable and may have experienced considerable, repeated traumatic events. Trauma informed care is vital cross all levels of interaction. This includes IEP providers, drug service providers and services offering specialist support. The concept of psychologically informed environments may also be relevant in which all aspects of service provision consider the psychological needs of service users.

Women may need to be encouraged to engage with sexual health clinics. Novel means of appealing to women may need considered. When women do attend there may be a crisis issue to be considered. An important finding across groups in service delivery was that non-judgemental care and advice was valued. For some users, particularly those involved in transactional sex and MSM involved in chemsex there may already be feelings of stigmatisation and possibly shame and a friendly approach will help initially to encourage use of the service.

Chemsex

Training and information giving on chemsex for staff in all health care settings.

Ongoing training, awareness raising and confidence building for BBV, drug use and sexual health services.

Training should include:

- Explanation of what chemsex is, drugs commonly used and discussion of common terms used
- Discussion around why people engage in chemsex, the benefits as well as the harms
- Information on the risks involved, including lack of ability to consent to sex as well as the particular risks involved for people who are living with HIV
- Discussion on how to have conversations with people about sexual health and drug use including over the phone/ via text / on-line, as well as in person
- Opportunities to practice asking questions around chemsex
- A variety of harm reduction strategies/resources and services available to support
- An awareness of the longer-term consequences on mental health, feelings of shame as well as practical issues of finance and impact on capacity to work are required

IPEDs

Training and information giving on IPEDs for staff in specialist health care settings and more general settings including pharmacies, general practitioners and accident and emergency clinical staff. All IEP providers would benefit from training on injecting practice technique for IPED users.

Ongoing training, awareness raising and confidence building for BBV, drug use and sexual health services.

Training should include:

- Explanation of what IPEDs are and discussion of terminology used
- Discussion around why people use IPEDs, the benefits as well as the harms
- Information on the risks involved, including injection related injuries
- Discussion on how to have conversations with people about sexual health and drug use including over the phone/ via text / on-line as well as in person
- Opportunities to practice asking questions around IPED use
- A variety of harm reduction strategies/resources and services available to support
- An awareness of the longer-term consequences on physical, mental and emotional health including depression and body image are required

Transactional sex

Training and information giving on transactional sex for staff in all health care settings.

Ongoing training, awareness raising and confidence building for BBV, drug use and sexual health services.

Training should include:

- Explanation of what transactional sex is and discussion of terminology used
- Information sharing on the drugs which may be used by people involved in transactional sex
- Discussion around why people engage in transactional sex, the benefits as well as the harms
- Information on the risks involved, including violence and lack of consent, as well as the risks of STIs, BBVs and unintended pregnancy
- Awareness of the vulnerability of women and the need for sensitive, trauma informed services
- Awareness of the structural and systemic barriers that exist for women to access services, and examples of how to remove these barriers
- Discussion on how to have conversations with people about sexual health and drug use including over the phone/ via text / on-line as well as in person
- Opportunities to practice asking questions around transactional sex
- A variety of harm reduction strategies/resources and services available to support
- An awareness of the longer-term consequences on mental health, feelings of shame as well as practical issues of finance and impact on capacity to work are required

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Appendix: Focus Group Findings

Glasgow Focus Group

16th October 2019 SDF offices, Duration 1hr 45 mins

Present

- IEP manager and IPED clinic manager
- Specialist sexual health nurse
- Specialist HIV MSM charity worker
- Specialist Hep C charity worker
- Transactional sex charity worker
- Sexual assault and referral centre (SARC) manager
- Sexual health improvement lead for NHS

Chemsex: Trends and patterns of use

- Increasing in MSM organisations and slight increase seen through SARC. Others in sexual health services suggested it was more hidden or struggle to identify numbers/lower numbers e.g. through IEP 110 clients registered in GGC (very low compared to other substances) Is it a small population?, are people getting equipment elsewhere?
- Issues with definitions- perhaps not clear enough. Clients' definitions different to standard definitions? Including other drugs e.g. cocaine
- Gaps in intelligence- low numbers in research but greater anecdotal reports.

  "definitely feels anecdotally to be something that's much more pressing than we can actually evidence in research currently"

  "we've struggled to identify the size of the population"

- Questions about chemsex could be better integrated in assessments
- Chaotic patterns and poor injecting practice in those that do come forward
- Older men? 40+ several men in their 60s
- Initially in Glasgow appeared to be link with men living with HIV who feel more stigmatised by commercial gay scene but found sense of identity in chemsex scene. Difficult to say whether that's changed? Lots of unanswered questions.

  "when we first saw the emergence of chemex in Glasgow, there did seem to be a clear link at that point to a population of men who were living with HIV who perhaps felt stigmatised' a bit shunned on the commercial gay scene, but some sense of identity in terms of that kind of protected chemsex party environment"

  " a lot of them are HIV positive men"

  "there's lots of questions, lots of unanswered questions round about chemsex and a lot of anecdotal data and I don't think we've managed to put the two things quite together yet"

- 50/50 split in sexual health between men who use specialist service and generic sexual health service- less knowledge in general service

  > “But actually, I think within our service historically, I think we've got something like a 50/50 split between gay men that use the specialist gay men service and gay men that use the generic service. So if we’ve put all of our resource round about chemsex knowledge in to only the bit of the service that’s specifically for gay men, and it’s not to say that even that training need has been completely satisfied, but it’s kind of ignoring all the staff that don’t rotate through that specific part of the service.. probably in terms of how our service intends to move forward, it’s more and more likely that gay men will use the generic part of the service more often”

- Parties in flats or B & B is often involving 24-48 hours of chemsex- issues with consent and traumatic experiences e.g. no memory, “step too far”
- What drugs- Crystal meth, GHB, mephedrone traditionally but clients also mention cocaine especially with regards to pre-loading prior to party. Viagra will also be used.

  > “the ones we see [in the SARC] are GHB and crystal meth”
  >
  > “I think cocaine is just out there, it’s not even considered in a way, it’s just normal”
  >
  > “People use cocaine “probably as a build up for going to the party, pre-loading I suppose”
  >
  > Viagra: It’s bloody hard to keep an erection and finish off when you’re taking coke…I think that’s an important combination”

- Groups vary in size- will be organised online. Often small groups out with city centre too through dating apps. Will go to other city locations across Scotland and Manchester or London on occasion. More common to see local parties now.
- Frequency-mixed: some occasional, some a regular part of their sexual experiences- can be hard to get clients to disclose chemsex, a lot of clients see a different worker every time they come in so don’t have a relationship.

  > “he was saying to me feel really anxious talking to his healthcare worker about chemsex because he felt this sense of altruism that he didn't want to let his healthcare worker down and was minimising that experience of chemsex because it almost felt like he would be letting them down by fully disclosing how chaotic and at times harmful it, trying to impress upon them. But your health care worker is there for is to support you with what's actually happening so try not worry about being judged because you should never be judged. But the service can only support you if you're able to fully disclose what it is you're experiencing”

IPEDS- Trends and patterns of use

- 3,500 users of IPEDS in IEP data (over a year).
- Drugs Anabolic/androgenic steroids, growth hormone, tanning agents, peptides.
- 500 individuals using IPEDs clinic- age range varied- largest group 25-30, very few under 18. A lot of secondary distribution of equipment so numbers likely to be far higher.
- Anecdotal reports from gyms- younger men seeking quick results.
- Research is negatively weighted to harms- relationship to creational drugs, whilst there is crossover, some people report they train heavily so use less recreational drugs
- Low BBV prevalence in Glasgow- low reports of sharing equipment.

Transactional sex: Trends and patterns of use

- Punters use drugs with them, being paid with drugs rather than money. More punters using crack. Having to spend longer time with clients and more commonly the transaction is for drugs and not for money.
- Punters using prostitution as way of sourcing drugs.
- Coercion for unprotected sex or removing protection during sex.
- Age ranges- older punters. Clients often typical range 18-30s for off street. Older for on street.
- Clients perception of exploitation and coercion by punters often different from workers. At risk young people seeking genuine relationships.
- On street workers- more chaotic and using heroin, valium etc., off street more likely to be cocaine and less chaotic drug use overall. Alcohol use also common but don't see use as problematic.
- Off street- range of settings- own houses, flats, hotels. Harder to engage with. Maybe more likely to feel in control.
- Mostly women that services are seeing but some engage with men. Much more hidden with men. No longer specialist service within NHS. Male core group tended to be in 30s but known to services for long period, but this changed to younger vulnerable men (LAAC). Some male sex work through saunas.

Risk behaviours/consequences

- Stimulant use affecting risk behaviours- more bravado, types of sex may be different, if injecting more likely to be chaotic. HIV incidences linked to injecting cocaine use in Glasgow
- Forgetting to take ARV and mental health meds
- Erratic and chaotic behaviours
- Acquiring STIs and BBVs particularly for chemsex events with larger numbers of people
- Feeling shame and stigma and not wanting to approach services
- Assaults more violent and prolonged- more injuries, rough sex, anal sex
- Underreported rape within transactional sex and chemsex
- Consent and blurred lines if intoxicated- being unsure what happened and just becoming aware of pain the next day
- Medical professionals may host chemsex parties and prepare drugs and support around injecting technique- this is normal in other drug use, initiation of injecting often by more experienced partner/peer. Could be positive?
- Large doses of testosterone- 'more horny' and may have more unprotected or rougher sex
- IPED clinic has limited links with sexual health- would be useful to have a specialist sexual health worker based in clinic, to do more STI testing for example.
- Reinfection of HCV amongst women involved in transactional sex and who inject drugs- unsure of reasons- sharing? Sex?
- Mental health consequences seen across all groups, often pre-existing and to different degrees.

  "it goes hand in hand" (transactional sex)

  "A little bit more complex is a smaller group that suffer from some form of body dysmorphia so are continually trying to change their shape and really aren't willing to take a break from use because they're so terrified about losing muscle mass and going back to their original shape" (IPEDs)

- Trauma and ACEs link with transactional sex

  "muddled sense of seeking affection"

Services that would be useful

- IPEDs- specialist counselling, confidential access to GP, endocrinologist, sexual health
- Transactional sex- some good existing links with services but opening times of e.g. addiction services often do not join up with this population. Often needs to be afternoon or may need support to attend initially e.g. buddying, bus tokens etc. Specialist trauma service needed- existing services can be up to 2 years waiting list.
- MSM- need for specialist counselling services- useful to have in house or have a named person in external service. These exist in NHS service-waiting list approx. 5 months. Can be criteria issues which mean clients should technically be seen by general MH services.
- SARC- better links with drug services needed
- Issues with MH referrals if clients using substances

Hidden populations - How do we ask?

- Challenges around assessment- routine enquiry vs more informal enquiry.
- Do clients expect comprehensive assessments in generic assessments?

> "if you're going in to a generic addiction service are you going to feel on the back foot if you're suddenly asked questions, maybe not, you might expect questions about gender based violence but would you expect broader questions around sexual health?"
>
> "in the client's mind, they are coming to use a specific service, were they really expecting that more comprehensive range of services and how prepared do they feel to answer"

- Issues of staff training and confidence but also client preparedness and understanding why they are being asked certain sensitive questions.
- How we ask is important. "the approach often is key to whether you're going to get a response and an honest response that then allows you to support them" (chemsex)

Training needs

- Greater need for chemsex training in generic sexual health services - need to bring it more in to consultations with clients
- Formats: Face to face sessions, Masterclass formats with variety of topics
- Training needs to be across all sectors
- Opportunity for knowledge exchange with colleagues form other services
- Training and awareness raising for GPs would be useful for IPEDs
- Training for prisons for transactional sex and the different forms e.g. in exchange for goods, drugs
- More in depth sexual health training is needed for staff working across these groups to include detailed STI knowledge and range of contraception methods
- Training should include how to open dialogues about chemsex, transactional sex and IPEDs
- Good to receive refresher training regularly
- Tapping in to lived experience of good harm reduction practices is useful as we tend to only focus on harms

Lothian Focus Group

SDF facilitated a focus group with 6 staff members from the Lothian area on Friday 20th September. The focus group was held at Chalmers, NHS Lothian, and lasted 2 hours (11am to 1pm).

6 participants:
- Nurse, harm reduction team, IPED clinic lead
- SX worker, part of Waverley care, sexual health for MSM
- ROAM outreach worker
- NHS, WFD policy and research worker, previous frontline
- Sacro – project working with all women who are involved in sex work, porn, off street, on street
- Salvation Army – street project, van – women involved in transactional sex

Chemsex

Context described by service participants

About 10% of service users they are supporting report chemsex –about 5 or 6 service users a week. The prevalence is not as much as reported in London. Definition of chemsex is using 2 or more substances, not necessarily slamming – although the definition used comes from London and doesn't fit with the Scottish scene. Around 25% of service users state they use chems while having sex, but this is not necessarily defined as chemsex. To define as chemsex – staff try to think of the wider impacts on someone's life – rather than just the chems use itself. This is a very intersectional population – they have many different aspects to their lives, and involvement in chemsex is just one of these.

Themes

Apps and online sites: Grindr, Squirt, Hot Mess, DILF are some of the key apps or sites used to arrange meets. DILF and Hot Mess more for travelling to pre-planned events, while Grindr and Squirt are used for more casual meets.

Variation on impacts from chemsex: There is variation on the levels of impact for service users. For some there is little wider impact on their lives, for example one service user will pre-plan to use chems once every 3 months, while another service user will steal from others to fund chems, as it is now all he can think about and can no longer have sober sex.

Financial Impact: Staff do see male sex workers as a result of one of the financial impacts of using chems. Especially for those who are not able to hold down a 9-5 Monday to Friday job due to chemsex involvement.

BBVs: HIV is the BBV on most service users' minds. Those who are HIV negative, are generally resigned to be HIV positive in the future. Those who access the needle exchange van who are HIV positive are very open about this, and most discuss U=U messaging. Hepatitis C is not on anyone's radar.

Testing Services: There is variation in which testing services people prefer. Some prefer the key third sector testing (SX) service as the staff are all gay men and there's a feeling that they understand and won't judge. Others prefer the confidentiality and anonymity of the NHS testing service (the staff are not on the "scene").

Risk taking: One event staff were told of included about 150 guys, all bare backing, some of whom are HIV+ with detectable viral load – while others were HIV-; men attending as a thrill – playing Russian roulette with HIV.

Sexual assault and sexual trauma: Sexual assaults are common though not reported. Consent is often blurred while people are using chems. Trauma to rectum and penis has been observed by staff who then signpost to A&E.

Condom Use: This is reported as declining amongst this population; however, this is not unique to the chemsex population: condom use is reportedly in decline across all populations.

Chems: G is purchased online but can't guarantee the strength. Staff have been made aware of necklaces with vials that can be prefilled with doses in each vial – as a way to control use and prevent overdose. Some are purchasing prefilled syringes where you can't be sure of substance, strength or sterility. Others report seeking new people every weekend to slam ecstasy with.

Support for Chem use: Staff signpost to Access practice for addiction support – and we also drop people off there if in urgent need of help.

IEP services: It is difficult to ascertain the prevalence of chemsex users at other needle exchange services such as pharmacy IEP as questions aren't asked due to staff feeling uncomfortable. In the experience of staff accessing the NEX van – most people are forthcoming when asked about s exuality and or chemsex – so an area to increase capacity of our understanding of this population, as most people involved in chemsex who access IEP will do so from a community pharmacy. Most service users access the correct equipment for the chems they are using and staff rarely see injecting injuries.

Mental health, shame and stigma: Mental health, shame and stigma are all entwined. Emerging from relations (or lack of) with family and also internal stigma of own sexuality.

Gaps in Services: Psychologists and counselling especially needed in this population. Community s upport is really important and could be more available for this population, while digital outreach is also a key area services could move into to reach this population.

Online information: When services try to use the apps and meetup sites to provide health promotion advice or advertise services they are usually kicked off. More could be done to build relationships with the sites to ensure people get the right advice on the sites they use. Crew website is good for drug info, and SX website has Chemsex info.

Staff Training: There is an MSM masterclass hosted in Lothian which is attended by a wide range of staff, including police and GPs. ROAM and SX staff train each other in their areas of speciality. It is an ever-changing field – so important for staff to stay on top of the new trends. Focus groups are especially important to ascertain the current situations. Staff in areas surrounding Edinburgh don't attend training as much as those in the city – probably due to training being very city centre focussed and services very Edinburgh centric.

Wider staff training in chemsex is required– such as A&E staff and GPs. Staff have only ever received one referral from a GP.

IPEDs

Context: See people less often than other groups. Usually see about 8 to 10 IPED users a night at the clinic in Edinburgh.

Substances used and how they are used: People usually buy various IPED products online: testosterone, trenbolone, boldenone. "Blast and Cruise" where someone first "blasts" by using steroids for 6-12 weeks then tapers down to a dose that is at about the level of testosterone the (usually) man would produce naturally. The chemistry is complex.

New Users: Under 25s – largest proportion of new injectors – steroids.

BBVs: Tested only 1-person for hep B ever. This population don't share injecting equipment. They learn about injecting first from online sources – such as YouTube – or in person if they enter the clinic.

Side Effects: Lots of varied side effects as the chemistry is complex. If using trenbolone – loss of libido and depression common. One teenager, severely bullied, started taking steroids, didn't know he also had to exercise, so got breasts. Surgery will be required for removal.

Mental Health: IPED services have to have a mental health focus. Counselling offered through IPED clinic over last year – there's been a huge uptake from service users. Clinic urgently requires a psychologist with OCD focus as there is a need in this population. Body dysmorphia is also prevalent – even if people don't think they are, but they become so obsessive over an inch of shoulder.

Mid Cycle and Post Cycle Bloods: "You need to offer people a reason to use your service". IPED clinic offer the mid cycle bloods as well as post cycle bloods – staff are very strict with it –bloods don't assess whether IPEDs are real or fake. Harm reduction advice is given based on mid cycle bloods. To get post cycle bloods they must follow the harm reduction advice given at mid cycle bloods.

Testosterone Replacement Therapy: Testosterone replacement therapy needs to be given consideration for users. If they don't have hormonal recovery they will develop an addiction as they can't cope without testosterone.

Information and Resources: Exchange Supplies have good resources. The Linnell book is also good.

Women: Only 1 woman at clinic who had severe body dysmorphia – this is a much more hidden population.

Data Collection: IPEDs clinic has a set of key questions they ask everyone, including alcohol and other drug use. But generally, a huge gap in recording of data.

DRD: Over the last year – there has been a couple of recorded drug related deaths within the IPEDs population – needs further research and advice to be produced for staff and users.

Gaps in services: Endocrinologist access low, gynecomastia and referrals to plastic surgeon. Mental health / psychologist with OCD and body dysmorphia focus.

IPEDS Clinic: Anonymous Clinic for people to use. Edinburgh clinic happy to speak with others to share the learning for others to set up their own clinic.

Transactional Sex

Context setting

Those involved in transactional sex, exchanging sex for money or drugs, is a much larger and hidden population than we know. 3 different groups with different needs: i) On street are usually older, and a more vulnerable population, usually 20s to 50s with large amounts of poly drug use; ii) those who sell sex within saunas are usually a more varied group in terms of vulnerability and age; and iii) those who sell online even more varied again – have ages accessing support from 18 to over 70.

Vulnerable women accessing outreach van: The population accessing the outreach van are mostly vulnerable, homeless women. All but one woman who access the van use drugs – the one woman who doesn't is a heavy alcohol user.

Themes

Drugs being used: Usually anything that is available; most are on OST and also using Xanax, crack, cocaine, heroin, alcohol.

Reasons for drug use: Reports that drugs are being used to numb pain. The women take drugs to cope with what they are doing; they are doing what they are doing to pay for their drugs. It is usual to hear women state that they need to use drugs in order to have sex: "I take these pills to prevent me crying when I have sex".

Increased vulnerability: Younger women can often be too chaotic to get onto OST and are exceptionally vulnerable. Staff can see women too intoxicated to work and know the women are not safe.
Reasons for transactional sex

Women are involved in transactional sex to fund drug use, and vice versa. However, in recent years there have been women who have re-entered sex work due to financial hardships. The number of women returning to the street is huge. 10-12 years away and now back due to needing money and drugs - quite usual to hear "I don't want to do this but it's my only choice to feed my weans".

Location of Sex: Salamander street use to be the main location for on street selling. Outreach van is no longer allowed there. Quite often women are picked up in cars or taxis and taken to flats. Staff on the van only occasionally see women who sell on online platforms such as adultworks or craigslist.

Outreach Van – Low threshold service: The staff who work on the van try and offer a service that focusses on being relaxed and building trust and relationships. This is usually a slow progress, but worth the effort once the women trust staff and the service. A year ago, there were very few women using the service, however with building trust the service is now provided to about 15 women a week. It's a service that is more likely to discuss last night's Coronation Street as opposed to pushing messages around sexual health, drug use or exit strategies. The ethos of this comes from "other agencies and punters all take a bit of the women, we try not to take anything from them".

Sexual Health service provision: There is no sexual health service available to women involved in street based transactional sex.Sexual health nurses will attend the outreach van. But sexual health clinics have no women only spaces, or out of hours provision for women involved in transactional sex. Sexual health provision for women involved in off street transactional sex is very good.

OST and IEP service provision: Women can now attend fortnightly for their script from Spittal Street – used to be weekly – so this is an improvement. There is no out of hours access to needles available – women report reusing needles all weekend and so at risk of BBVs. The van is not allowed to provide naloxone to women involved in transactional sex as the service is not defined as a drug service even though they are supporting very vulnerable drug users and giving out IEP equipment.

Out of Hours provision required: Drug services need to be open later – women go to Leith links, make money, take drugs then sleep, and they are up until 6 or 7 in the morning – they will miss day appointments as they can be asleep until services close. These women sleep all day, and work or use drugs all night – services are just not set up for them. Thought needs to be given to create services for these women so they are not penalised and marginalised further, such as removal of the 3 strikes policy.

Engaging women: Staff need to feel confident just to ask the question "are you exchanging sex for money or drugs" - some women are waiting for you to ask. Sometimes the staff on the van can be the only people who know the women are involved in transactional sex, even though they have other workers.

The women want to be treated as human beings. They usually have huge vulnerabilities – if in doubt, just chat – offer support where and when they choose -if they are working on street stop invading their space and leave them alone to "work".

Complex health needs: Personality disorders, schizophrenia, huge variations in diagnosis. People need neurology specialists and help with other complex health needs – they generally need everything. Physical health needs are huge. Nurses come onto the van or to Spittal Street on Thursdays. If they have open wounds, they can be referred onto infectious disease ward.

Staff training: Half day multiagency training offered by SACRO which includes indicators of sex work, drugs, homelessness etc. They also provide training on drugs and mental health. Training needs for staff – vicarious trauma.

Children removed from care: Children are often removed from their mothers. One woman now 7/8 months pregnant – she thinks she will get to keep the baby – but she has had others taken into care. Woman in Niddrie Street - children taken away, only gets 30min to 2 hours contact – the focus is on the baby not the mother. Mothers are not getting supported through this.

Motherhood: Usually no one else knows they sell sex – don't want to report it to services which makes the women more vulnerable. If the women do have children in their care then providing for children is a motivator "I don't want to do this but it's my only choice to feed my weans" also the children will usually be told their mums are cleaning at night as a way to keep what they do secret.

Condom Use: Most women will state they always use condoms. However, many men will offer more money for condomless sex.

Trauma Informed Services: To respond to the needs of these women more trauma informed mental health services and psychologists are needed. A national resource to prevent burnout of staff working with people with history of complex trauma is also needed.

Relationships between women: The relationships between the women on the street is very complex. They will love and support each other and then hate and compete against each other.

Fife Focus Group

Participants:
- BBV Nurse – 4 years
- BBV support staff – 1 month (previously prison health worker)
- Addictions Nurse - 4 years (women offending team)
- Senior Addictions Nurse – 3 years
- Student Nurse
- BBV service user involvement officer 5 years (previously in drug and alcohol service planning and commissioning 10 years)

Apologies from sexual health nurses and advisors, 3rd sector needle exchange staff, SACRO, 3rd sector rehabilitation worker.

All of the staff who were present tended to work with the same addictions populations and were NHS based. It was agreed that the information on Chemsex and IPED use would have been more in depth if all the staff above had been able to attend. Transactional sex was the topic that had the most discussion.

Chemsex

Only BBV nurses have worked with MSM populations. Those participating did not know of the prevalence of chemsex itself. One addictions nurse felt that their male clients may be exploited by other males for heroin or cocaine. There is a PrEP clinic that is believed to have a percentage of men who hook up through apps and meet other men for sex while using drugs. It is not known which drugs are used by these clients.

Support / provision for MSM is by Terence Higgins Trust but whether that's well known was unclear. Addictions staff have not had to seek support for LGBT issues.

IPEDs

The only experience the staff who were present have seen is among very few male clients who are using steroids for appearance. IPED users are accessing needle exchange and chemists for IEP.

Transactional Sex

The addictions nurses have worked with both men and women involved in transactional sex. No one is forthcoming about their involvement in selling sex, but men are much less likely to discuss. Women use dating apps and websites to sell sex as well as via shared social media groups. There is no on street location and women report selling online. Men report buying sex using Vivastreet where Eastern Europeans are working from local flats. Some clients report it being something they used to be involved in. Young females are accessing sexual health clinics to prove they are HIV negative and are not part of addictions population.

Support for transactional sex – there is a new CLICK worker for people involved in transactional sex. This online service is brand new, so staff are unlikely to know it exists.

Themes Discussed

Drugs (across groups)

- Drugs linked with chemsex have not been seen by this staff group.
- Transactional sex and addictions population in general are using heroin, crack cocaine, ORT, gabapentin, benzodiazepines. Frequency of Injecting heroin is decreasing due to escalating cocaine use.
- IPEDs – available from gyms. Recently drug dealers cuckooing alongside all other drugs
- Cuckooing is becoming a problem in different parts of Fife with 5 cases being noted among those participating where clients have had people form large English cities who move in and provide free drugs for the tenant and deal from the tenant's home.

Crack cocaine use – this concerns all of the clients in addiction services
- Is now a Fife wide issue
- Is being sold in £10 rocks – people spending lots, leading to debts
- Staff have gaps in knowledge and feel they need to know more about how to provide harm reduction advice especially around: Sharing / group use / communities full of dealers / cuckooing

Universal credit

- Changeovers and sanctions have left people with no money and has impacted on some individuals who then turn to selling sex.

Assessments

There is a generic risk assessment in sexual health. It routinely asks about
- Selling sex
- Sexuality
- Injecting drugs

Forms do not ask about chemsex specifically or about whether people are safe in their personal relationships (this would be helpful as issues of gender-based violence were highlighted).

Also assessments are always carried out initially and are not ongoing so staff often ask difficult questions (about crime and sex work, childhood abuse etc.) before any relationship is established.

Women only space

There are no women only spaces in addictions or sexual health but this was highlighted as a need. There's also a need to better utilise mobile units – these could be used as gender specific spaces.

Models of holistic care highlighted

WINGS – women's offending team have the time to work with females on all issues and are able to support women to address BBVs.

BBV Nurses – HIV and Hepatitis patients still get treatment even though they take drugs. A holistic service is provided to look after all the issues: they have a psychologist, carry out sexual health screening and have their own citizen's advice clinic for patients. The BBV nurses aim to deal with every issue the

client has rather than refer to multiple services. Their hep c patients are mainly injecting drug users and their HIV patients were infected through sexual transmission. A recent outreach chemist testing pilot picked up a drug user who has cleared HCV but tested positive for HIV.

Training needs

- Cocaine use
- Identifying vulnerability and identifying when and how to respond if there's coercion
- Confidence and having chats about transactional sex
- Face to face training preferred in house half day – do not like online training as never get round to it (for all 3 populations)

SDF harm reduction staff piloted some training on cocaine and practical harm reduction to nursing staff.

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