

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



Bourne, A; Reid, D; Hickson, F; Torres Rueda, S; Weatherburn, P (2014) The Chemsex study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark and Lewisham. Technical Report. Sigma Research, London School of Hygiene & Tropical Medicine, London.

Downloaded from: <http://researchonline.lshtm.ac.uk/2197245/>

DOI:

#### Usage Guidelines

Please refer to usage guidelines at <http://researchonline.lshtm.ac.uk/policies.html> or alternatively contact [researchonline@lshtm.ac.uk](mailto:researchonline@lshtm.ac.uk).

Available under license: <http://creativecommons.org/licenses/by-nc-nd/2.5/>

# The Chemsex Study:

drug use in sexual  
settings among gay  
and bisexual men in  
Lambeth, Southwark  
& Lewisham

Adam Bourne  
David Reid  
Ford Hickson  
Sergio Torres Rueda  
Peter Weatherburn

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



**Sigma**  
RESEARCH

Lambeth



Southwark  
Council



Lewisham

# ACKNOWLEDGEMENTS

This report was commissioned by the London Boroughs of Lambeth, Southwark & Lewisham. Their commissioning manager, Paul Steinberg, was the driving force behind the conception of this study and he provided significant practical and intellectual support at every stage. It could not have happened without him.

A large number of other people also contributed to the success of this project. Our thanks go to Monty Moncrieff (London Friend), David Stuart (56 Dean Street), Valerie Delpech & Vicky Gilbert (Public Health England), Patrick Cash & James Eagan (QX Magazine), Simon Kilner (The Eagle), Gavin Simpson (Disco Damaged), staff of The Hoist club (Vauxhall), Phillipe Chiarella (Orange Nation), Steven Warren (RVT), Justin Harbottle (THT), Michael Peacock and Maria Kinsella (Chemsex community forums), the Vauxhall One business association, Uli Lenart and Jimmy MacSweeney (Gay's the Word), Christopher Camplin, and Matthew Hodson (GMFA). We particularly wish to acknowledge the support of the Metro Centre staff and volunteers (especially David Naylor, Rob Wardle and Tony Furlong) for helping to inform the study, as well as hosting and participating in focus groups. Thanks to Kathie Granger for her expert project administration, to Gary Hammond for proof-reading and to Siân Cook for her design of this report.

Finally, this study would not have been possible without thirty men stepping forward to talk openly and honestly with us about their experiences. We are greatly indebted to them. We also sincerely thank all those who took part in focus groups, as well as the staff and volunteers from community based organisations and sexual health clinics who gave up their time to share their thoughts and experiences.

## **Adam Bourne**

Lecturer

Sigma Research Group

London School of Hygiene & Tropical Medicine

Adam.bourne@lshtm.ac.uk


**Suggested citation:** Bourne A, Reid D, Hickson F, Torres Rueda S, Weatherburn P (2014) *The Chemsex study: drug use in sexual settings among gay & bisexual men in Lambeth, Southwark & Lewisham*. London: Sigma Research, London School of Hygiene & Tropical Medicine. [www.sigmaresearch.org.uk/chemsex](http://www.sigmaresearch.org.uk/chemsex)

Published by Sigma Research, London School of Hygiene & Tropical Medicine. March 2014. ISBN: 978-1-906673-18-5

# TABLE OF CONTENTS

<b>Acknowledgements</b> .....	2
<b>Glossary of key terms</b> .....	6
<b>1. Introducing ‘chemsex’</b> .....	8
1.1 Understanding the prevalence of chemsex in London .....	10
1.2 The public health problem.....	10
1.3 Chemsex in Lambeth, Southwark and Lewisham.....	11
1.4 Chemsex in an international context.....	13
1.5 Overview of report.....	13
<b>2. Methods</b> .....	14
2.1. Secondary analysis of EMIS Survey data .....	15
2.2 Qualitative interviews.....	15
2.3 Focus groups with members of local gay community.....	16
2.4 Focus group & interviews with community and clinical service providers.....	16
<b>3. Drug use among MSM living in Lambeth, Southwark and Lewisham: survey data from EMIS</b> .....	17
3.1 The EMIS Sample.....	18
3.2 Sample demographic characteristics .....	18
3.3 Injecting drug use .....	19
3.4 Recency of drug use by men in LSL .....	20
3.5 Drug use in LSL compared with elsewhere .....	22
3.6 Variation in drug behaviours and needs across demographic groups.....	23
3.6.1 Age .....	23
3.6.2 HIV testing history .....	24
3.7 Use of gay settings .....	25
3.8 Setting use and drug use.....	26
3.8.1 Gay café/bar/pub use and drug use.....	26
3.8.2 Saunas and drug use.....	27
3.8.3 Backrooms/sex clubs and drug use.....	28
3.8.4 Private sex parties and drug use .....	29
3.9 Summary .....	30

<b>4. The context of chemsex .....</b>	<b>31</b>
4.1 Drugs of choice for chemsex .....	32
4.2 Drug use initiation narratives.....	33
4.3 Means of drug delivery including injecting .....	34
4.4 Means of acquiring drugs .....	36
4.5 Settings for chemsex.....	37
4.6 The social and community context of chemsex.....	38
4.7 Summary.....	40
<b>5. The impact of drugs on sexual pleasure and sexual performance.....</b>	<b>41</b>
5.1 Facilitating sexual confidence .....	42
5.2 Increasing sexual desire and libido .....	43
5.3 Intimacy and sexual connection .....	44
5.4 Sexual longevity and partner turnover .....	45
5.5 Enabling sexual adventure .....	45
5.6 Sexual (un)happiness and making sex better .....	47
5.7 Summary.....	48
<b>6. The role of drugs in HIV/STI transmission risk behaviour.....</b>	<b>49</b>
6.1 Pre-determined STI risk behaviour .....	50
6.2 Unintended sexual risk under the influence of drugs.....	52
6.3 Using drugs to rationalise risk-taking .....	54
6.4 Strict maintenance of safer sex behaviour .....	55
6.5 Summary.....	56
<b>7. Negative experiences and harms associated with chemsex.....</b>	<b>57</b>
7.1 Harms related to physical health.....	58
7.1.1 Overdosing, and subsequent harms.....	58
7.2 Harms related to mental health .....	60
7.3 Lost time .....	60
7.4 Harms related to employment and finance.....	61
7.5 Social and relational harms .....	61
7.6 Harms related to the gay community .....	62
7.7 Summary.....	62



<b>8. Managing drug use and getting help</b> .....	63
8.1 Maintaining control over drug use .....	64
8.2 Managing dosing .....	65
8.3 Managing life’s other commitments .....	66
8.4 Managing temptation.....	66
8.5 Getting help with drug use.....	67
8.6 Summary.....	69
<b>9. Recommendations</b> .....	70
<b>10. References</b> .....	71

# GLOSSARY OF KEY TERMS

TERM	DEFINITION
<b>AIDS</b>	Acquired Immune Deficiency Syndrome.
<b>Arse play</b>	The use of objects made of rubber or other pliable substance, to penetrate the rectum for sexual stimulation. Can also be used to refer to fingers or fists.
<b>Barebacking</b>	See 'Unprotected anal intercourse (UAI)'.
<b>BDSM</b>	Bondage, Domination, Sadism, Masochism. Kinky sex or role playing that involves some form of bondage, discipline, domination, submission, sadism, and masochism.
<b>Bug chasers</b>	People purporting to be HIV negative but who say they want to contract HIV.
<b>Bump</b>	A subjectively small measure of a drug that can be taken in one inhalation or insertion.
<b>Booty bump</b>	Occurs when drugs are mixed with water and injected into the rectum with a needle-less syringe cartridge, or in powder or tablet form pushed in with a finger, penis or sex toy.
<b>Bottoming / Bottom</b>	Being the receptive partner during penetrative anal sex.
<b>Chasing the Dragon</b>	A term commonly used to describe the elusive pursuit of the ultimate high in the usage of some particular drug.
<b>Chemsex</b>	Engaging in sexual activities while under the influence of drugs. Often involves group sex or a high number of partners in one session.
<b>Chill Out Party</b>	Traditionally referred to as a way of socialising to relax and let the effects of drugs and alcohol wane after a main event; such as a night clubbing. They were traditionally social rather than sexual. The term is commonly now used to describe a private house party after clubbing, which includes the continuation of drug use and sexual behavior.
<b>Club Drugs</b>	A selection of drugs that are commonly or typically used in connection with attending nightclubs, bars, festivals, concerts, parties or sex on premises venues to enhance sociality, enjoyment of music, dancing or sex.
<b>Come down</b>	Psychological and physical withdrawal from the effects of drugs and the experience of using them. Generally perceived as an unpleasant or negative experience.
<b>Cruising location / cruising ground</b>	A public place such as park, bus station or toilet facilities where there is potential for men to meet each other and have sex.
<b>Dissociative</b>	(A class of hallucinogen) which distorts perceptions of sight and sound and produces feelings of detachment and dissociation – from the environment and the self.
<b>Fetish club</b>	A club oriented to people interested in sexual activity where particular sexual acts, roles, clothing or toys are eroticised. Sex often occurs in public areas of the venue.
<b>Fisting / Double fisting</b>	Inserting the hand (and sometimes the forearm) or two hands into the anus and rectum of a sexual partner.

TERM	DEFINITION
<b>Gay Commercial Scene</b>	The infrastructure developed to facilitate the socialisation of gay or bisexual men. It may include bars, clubs, saunas, physical and online retail environments, magazines, social networking websites and apps, plus and gyms and sex work.
<b>G hole or K hole / “Going under”</b>	Overdose with GHB or GBL with resulting loss of cognitive functioning, physical control, consciousness, sleep and / or coma or a dissociated state with ketamine with feelings of depersonalisation and disorientation. To “go under” is to be less conscious or unconscious.
<b>Geosocial networking applications (apps)</b>	Social networking is web-based service that allows individuals to create a public profile, and interact with other people within a contained system. Geosocial networking apps also provide information on the geographic location of a user relative to others. There are several apps that cater specifically for gay men and are commonly used to find partners for sex or relationships.
<b>Harm reduction</b>	Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of drugs. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself.
<b>HIV</b>	Human Immunodeficiency Virus.
<b>LSL</b>	The geographic area that constitutes the London Boroughs of Lambeth, Southwark and Lewisham.
<b>MSM</b>	Men who have sex with men.
<b>Party and Play (PnP)</b>	An alternative term to ‘chemsex’ (described above).
<b>PEP to</b>	Post Exposure Prophylaxis – is any preventive medical treatment started immediately after exposure to a pathogen (in context HIV), in order to prevent infection by the pathogen and the development of disease.
<b>Rimming</b>	The stimulation of one man’s anus with another man’s tongue.
<b>Sero-sorting</b>	A term used to describe the practice of choosing partners or sexual behaviours in relation to the perceived or known HIV status of both sexual partners.
<b>Sex on premises venues / sex clubs / backrooms / darkrooms</b>	Venues such as nightclubs, clubs, saunas where sex is sanctioned or space is provided for sex to happen on the premises. Backrooms are spaces for sex within clubs that are away from the general social areas.
<b>Sex Party / Sex party scene</b>	A party usually hosted in a private residential home whose primary function is group sexual interaction. ‘Scene’ refers to regular participants and organised parties where participants may overlap, move between or regularly attend parties.
<b>Slamming</b>	Intravenous injection of drugs (via a syringe and hollow needle).
<b>STI</b>	Sexually Transmitted Infection.
<b>Topping / Top</b>	Taking the insertive role in penetrative anal sex.
<b>Unprotected anal intercourse (UAI)</b>	Anal intercourse where a barrier such as a condom is not used.

Elements of this glossary have been adapted, with permission, from training materials produced by Paul Steinberg.



# 1. INTRODUCING CHEMSEX

Research conducted over the last twenty years indicates that a higher proportion of gay men both in the UK and abroad use drugs than is the case for the general population (UK Drug Policy Commission, 2010). Such usage in the UK and, in particular, London, has historically centred around ‘club drugs’ such as ecstasy, cocaine, ketamine or LSD (Weatherburn *et al*, 1999; Keogh *et al*, 2009). As is the case with most big cities around the world, drug use is more common among gay men in London than in other parts of the UK (Bourne, 2012).

Recent evidence, however, indicates shifting trends in drug use among some gay men, both in terms of the most popular drugs and the way in which they are used. The term ‘chemsex’ or, to a lesser extent, ‘Party and play’, has entered the vocabulary of certain sections of the gay population is a behaviour that has attracted significant media attention. **Chemsex is commonly understood to describe sex between men that occurs under the influence of drugs taken immediately preceding and/or during the sexual session.** As this report will describe in more detail, the drugs most commonly associated with chemsex are crystal methamphetamine (hereafter referred to as ‘crystal meth’), GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine (see [TABLE 1](#)). All except ketamine, have stimulant properties in that they typically increase heart rate and blood pressure and trigger feelings of euphoria, but crystal methamphetamine, GHB/GBL and mephedrone also have a common effect of facilitating feelings of sexual arousal. These drugs are often taken in combination and are commonly associated with sexual sessions occurring over extended periods of time, sometimes involving large numbers of sexual partners.

**TABLE 1** Drugs commonly associated with chemsex among gay men

NAME OF DRUG	STREET NAMES	HISTORY	DELIVERY	EFFECTS	POSSIBLE SIDE-EFFECTS
<b>Mephedrone</b>	Meow Meow, MCAT, plant food	A class B drug that has been illegal in the UK since 2010. It has been popular in the UK since 2008, when it first reached the UK market as a “legal high”.	Swallowed in tablet form, snorted as a powder, injected, or administered rectally (‘booty bumping’).	Euphoria, enhanced appreciation for music, elevated mood, decreased hostility, improved mental function and sexual stimulation.	Anxiety and paranoia, overstimulation of the heart, circulation and nervous system, leading to a risk of fits.
<b>GHB/GBL</b>	G, Gina, liquid ecstasy	Gammahydroxybutrate (GHB) and GBL gammabutyrolactone (GBL) have closely related effects. Both are class C drugs.	Swallowed in small liquid doses, or added as a powder to a soft drink. Occasionally injected.	Euphoria, lowered inhibitions, increased sex drive. Often used to boost the effect of other drugs. Relaxant effects can make receptive anal intercourse easier or more pleasurable.	Memory lapses, clumsiness, drowsiness, tremors, agitation. Very risky to take in combination with alcohol and/or amphetamines. Overdose can trigger a ‘G sleep’ – a state of unconsciousness that may require medical intervention.
<b>Crystal methamphetamine</b>	Crystal, tina, meth, ice, T	Essentially a more pure form of methamphetamine (a stimulant). Class A drug.	Smoked in a glass pipe, snorted as a powder, mixed with water and injected or administered rectally.	Euphoria, increased energy during sex or dancing, enhanced confidence, feelings of invincibility and impulsivity, reduced experience of pain, intense sexual stimulation, and lowered inhibitions.	Sleep disruption, loss of appetite, tremors or convulsions, irregular heartbeat, Comedown associated with feelings of depression, exhaustion and paranoia.
<b>Ketamine*</b>	K, special K, vitamin K	Classified as a Class C drug in 2006 but recently (12 February 2014) reclassified as a Class B drug.	Swallowed in tablet form, snorted as a powder, or injected.	At sub-anaesthetic doses, ketamine produces a dissociative state, characterised by a sense of detachment from one’s physical body and the external world. At sufficiently high doses, users may experience what is called the “K-hole”, a state of extreme dissociation with visual and auditory hallucinations.	Confusion, agitation, panic attacks, impairment in short and long term memory and depression (in long-term users). Can cause hardening of the walls of the bladder and problems urinating among regular users (ketamine bladder).
<b>Cocaine*</b>	Coke, Charlie, snow, blow	Class A stimulant drug, illegal to possess since 1916.	Snorted as a powder or smoked (typically as ‘crack cocaine’).	Increased energy, confidence, and feelings of exhilaration. People using cocaine often describe feeling more sociable, talkative and physically strong.	Raised body temperature and heart rate, with associated risk of heart attack. Longer-term damage to cartilage separating nostrils.

\* These drugs are not as commonly associated with chemsex, although they were mentioned by some men interviewed in this study and are thus included here for information

## 1.1 UNDERSTANDING THE PREVALENCE OF CHEMSEX IN LONDON

While the notion of ‘chemsex’ has received significant media attention, and been the subject of much community discussion in the last 12 months, evidence relating to the extent of drug use during sex is limited. Published data from the Antidote service (part of the charity, London Friend), which sees over 8,000 lesbian, gay, bisexual and transgender people every year, indicate a sharp rise in the number of gay and bisexual men presenting to the service with problems relating to crystal meth, GHB/GBL and mephedrone (Stuart, 2013). In 2005, these three drugs were responsible for 3% of all presentations among gay and bisexual men, but this had risen to 85% by 2012. Nearly all crystal meth use was reported within sexual settings, while 75% and 85% of mephedrone and GHB/GBL users respectively said they used the drug solely to facilitate sex. There was also a sharp rise in the number of gay male clients being referred to Antidote via sexual health clinics (Stuart, 2013). Data collected by the CODE clinic (a specialist sexual health service part of the Chelseas and Westminster NHS Foundation Trust that caters for gay men who are in a harder sex scene and/or use drugs) in 2012 showed that 19% of MSM (men who have sex with men) clients had used GHB/GBL in the previous 6 months, while 10% had used crystal meth and 21% had used mephedrone within the same period. All figures of drug use were significantly higher among men with diagnosed HIV (Scrivner *et al*, 2013).

In addition to these broad changes in the types of drugs used, there is some evidence to suggest a change in drug administration patterns. Among Antidote service

users in 2012, 80% of men who reported using crystal meth or mephedrone in a sexual context said they did so intravenously (a rise from 20% of clients in 2011). Similarly, data from the CODE clinic, which were reported in a Lancet news story (Kirby & Thornber-Dunwell, 2013) show that in 2011, 30% of their service users who reported using crystal meth said they injected this drug. This figure had risen to 80% by 2012. Among patients seen at the Club Drug Clinic (part of Chelsea & Westminster Hospital) in 2011-2012, nearly a quarter (24%) said they were currently injecting drugs, and another 18% reported injection drug use in the past (Kirby & Thornber-Dunwell, 2013). These high levels of injecting drug use among gay male clients at these specialist services stands in contrast to a large body of both national and international literature which shows levels of injection drug use among this population to be relatively low (for review see Bourne, 2012), although there is recent indication of injection drug use among gay men in Paris (Foureur *et al*, 2013).

While this clinic and service data about changes in types and delivery of drug use is compelling, there is a limit to what we are able to infer regarding drug use in sexualised settings among the population of gay and bisexual men more broadly. Changes in clinical presentations could reflect changes in drug use among gay men broadly, but could also be the result of improved visibility and awareness of these services and improved referral pathways between professional services that work to meet the health needs of gay men.

---

## 1.2 THE PUBLIC HEALTH PROBLEM

The perceived rise in the use of drugs during sex has prompted concern about the possibility of high-risk sexual behaviour. The association between drug use and HIV transmission risk has been the subject of intense research for 25 years, and the relationship is complex. While it is not possible to say that using drugs causes sexual risk-taking behaviour, it is possible to say that there is an association between the two: men who use a range of drugs during sex are more likely to report engaging in HIV transmission risk behaviours than men who do not (for a review of literature on this topic see

Diguisto & Rawstone, 2013 or Mayer *et al*, 2006). A significant amount of research has been undertaken to understand the role of methamphetamine in HIV transmission risk behaviours, particularly in the USA. This drug can cause feelings of hypersexualisation and is commonly utilised as part of sexual marathons (protracted periods of sexual activity) and group sex activities (Prestage *et al*, 2009; Semple *et al*, 2009). Ensuing rectal trauma can facilitate the transmission of HIV and other infections. Numerous studies have suggested that the use of methamphetamine causes

high-risk sexual behaviour (Fisher *et al*, 2011; Forrest *et al*, 2010) perhaps via a myopic mechanism (i.e. people become cognitively blind or blinkered to the possible consequences of their actions) or by the removal of sexual inhibitions. However, other studies have challenged this causal pathway (Groves *et al*, 2008; Rawstone *et al*, 2007).

Other associations with high-risk sexual behaviour have been identified in relation to ecstasy (Klitzman *et al*, 2002), GHB/GBL (Carey *et al*, 2009) and ketamine (Rusch *et al*, 2004). Men who reported polydrug use in the recent past (up to three months) are more likely to report HIV risk behaviours than men who took only one drug (Halkitis & Parsons, 2002; Fernandez *et al*, 2005). Data collected by the CODE clinic in early 2013 shows that 36% of respondents to their in-clinic, cross-sectional survey said they were more likely to engage in unprotected anal intercourse while under the influence of drugs (Scrivner *et al*, 2013). In the past 12 months, several commentators have suggested in media reports that chemsex may, in part, be responsible for a rise in HIV incidence among MSM observed over the last few years (Cooper, 2013; Morrison, 2014; Roberts, 2013), although there is no definitive evidence of this association to date.

The potential for HIV transmission to occur is increased when having sex with with large numbers of partners, as is the transmission of other STIs including hepatitis C, syphilis and shigella. In addition, concern has been raised as to whether men with diagnosed HIV are sufficiently adherent to anti-retroviral therapy (ART) while engaging in chemsex. Data collected by the Antidote service (Stuart, 2013) show that 60% of their gay male clients with diagnosed HIV said they have not been completely adherent to their medication while engaging in drug use during sex. Emerging scientific

consensus is that individuals with diagnosed HIV and who have an undetectable viral load (which is established by adherence to ART) are not infectious to their sexual partners (Cohen *et al*, 2011; Granich *et al*, 2009; Rodger *et al*, 2014). Therefore, it follows that ART non-adherence, and a potential increase in viral load, could be a factor in onward HIV transmission.

In a population of gay men where levels of injecting drug use have historically been low, there has also been concern raised about the possibility of needle sharing or other unsafe injection drug practices (Channel 4 News, 30 January 2014). All drugs require careful dosing and safe usage requires awareness of potentially dangerous combinations. However, crystal meth, mephedrone and GHB/GBL are all relatively recent additions to the gay social scene and the extent to which gay men are aware of harm reduction advice is unclear.

GHB/GBL is typically taken in very small doses diluted in water or soft drinks. Just a very small overdose (as little as half a millilitre) can lead to a 'G sleep' – a state of unconsciousness in which the individual requires careful monitoring to avoid choking, and higher overdose can lead to respiratory depression. Use of crystal meth can cause loss of appetite, disturbed sleep and panic attacks, while longer term usage can trigger psychosis, exhaustion and variety of tissue damage. Overdosing of mephedrone can cause overheating or an elevated heart rate, the likelihood of which is enhanced if taken with other stimulants, such as MDMA or cocaine. Similar symptoms might be observed in relation to crystal meth, although confusion, paranoid or aggressive behaviour is also common place if overdosing occurs (see [TABLE 1](#)). For more information on drugs effects and harm reduction information, see [www.drugscience.org.uk](http://www.drugscience.org.uk) or [www.talktofrank.com](http://www.talktofrank.com).

---

### 1.3 CHEMSEX IN LAMBETH, SOUTHWARK AND LEWISHAM

Lambeth, Southwark and Lewisham are each home to large populations of gay and bisexual men (Ruf *et al*, 2011) and to men living with diagnosed HIV (Health Protection Agency, 2011). Indeed, Lambeth is home to largest estimated population of gay men anywhere in the UK. There is a very large commercial gay scene in the north-central regions of the three borough, which contain clubs previously associated with drug use (Measham

*et al*, 2011) as well as sex-on-premises venues, such as saunas. There are also numerous other gay bars and clubs spread across the rest of Lambeth, Southwark and Lewisham. Within the past two years there have been a number of drug related casualties among gay men in clubs or sex-on-premises venues in Vauxhall that has been reported in the media (Morgan, 2012; Hopkins, 2011; Reid-Smith, 2012), indicating a significant degree

of harm reduction need among this local population. Between 2007 and 2012 there were 96 ambulance call outs relating to accidental or unknown drug overdose in the Vauxhall area during the hours of the night-time economy, although it is not possible to disaggregate this data by sexual orientation (Clark, 2013). The drug

most commonly associated with emergency admission to St. Thomas's Hospital in Lambeth in 2010 was GHB/ GHL, resulting in 270 presentations (Wood *et al*, 2013), although similarly it is not possible to disaggregate the data according to sexual orientation.

## AIMS OF THE CHEMSEX STUDY

This report was commissioned by the London Boroughs of Lambeth Southwark and Lewisham in order to understand the issues associated with chemsex in greater detail and to inform strategic commissioning intentions. The research sought to:

1. establish and describe the personal and social context of sexualised drug use among the population of gay men resident in Lambeth, Southwark and Lewisham;
2. understand the harms perceived or experienced by gay men who use drugs during sex including, but not limited to, sexual health and the possible transmission of STIs and HIV;
3. identify motivations, meanings and values associated with sexualised drug use among this population and how these might be altered;
4. generate recommendations for policy and practice to meet the complex needs arising from drug use during sex.

The research described in this report focuses on the use of specific drugs (crystal meth, GHB/GBL and mephedrone) in sexual settings rather than on drug use among gay men per se, and does not address use of performance enhancing drugs such as steroids. Whilst this research was commissioned by the HIV and sexual health team, it will have wider implications for many service areas, providers and commissioners.

## 1.4 CHEMSEX IN AN INTERNATIONAL CONTEXT

The majority of studies about drug use and sexual behaviour seek to understand the link between drug taking and the risk of acquiring or transmitting HIV. As stated earlier, this association is complex and still subject to significant debate. Such research is not often framed in terms of ‘chemsex’ or ‘party and play’ and is often narrowly focused on sexual health risk. A small number of studies that explore drug use during sex on a more holistic level, including the reasons for initiation and maintenance and the costs and benefits associated in the behaviour, have been conducted in the United States, with several others in UK (Keogh *et al*, 2009) and Australia (Hurley & Prestage, 2009). Typically, published

papers focus on specific behaviours associated with chemsex, such as group-sex activities (Prestage *et al*, 2009) or have specifically explored chemsex in relation to HIV status (Nakamura *et al*, 2009). Using drugs to enhance sexual experience and reduce sexual inhibitions is widely reported (e.g. Mattison *et al*, 2001; Kurtz, 2005; Bauermeister, 2007), as well as using drugs during sex to facilitate intimate connections with other men (O’Byrne & Holmes, 2011). Some research suggests that engagement in chemsex is seen by some men with diagnosed HIV as a means of cognitively escaping from the reality of their HIV status and lessens fears of rejection from sexual partners (Semple *et al*, 2002).

---

## 1.5 OVERVIEW OF REPORT

Chapter 2 of this report describes the methods used to address the aims stated above. Chapter 3 provides results of a detailed, secondary analysis of existing quantitative data about drug use among gay men. The 2010 European MSM Internet Survey (EMIS) had large samples of men living in Lambeth, Southwark and Lewisham and numerous questions relating to drugs taken, time period of use, and gay social spaces frequented. Chapters 4-8 describe the findings of our in-depth qualitative study of chemsex among gay men living in the three boroughs of interest, including 30 one-to-one interviews with gay men who engage in chemsex, as well as focus groups with members of the gay community, and interviews

with health and social care providers. Chapter 9 sets out recommendations for policy and practice in response to the needs identified.

In chapter 4 we provide three short vignettes that tell fictional stories of three individuals who experience chemsex in different ways, and for whom different interventions may be appropriate. These are composite narratives, in that they piece together fragments from several peoples’ stories, providing a more holistic view of how some men experience and think about chemsex, while still preserving the anonymity of actual participants.

## 2. METHODS

Between August 2013 and February 2014 we undertook a series of interlinked research activities, which sought to address the research aims outlined in chapter 1. These included: a secondary analysis of 2010 survey data from respondents in Lambeth, Southwark and Lewisham (LSL); a series of 30 in-depth interviews with gay men living across the three boroughs who reported engaging in chemsex at some point over the previous 12 months; three related focus groups conducted with members of the local gay community as well as community service providers; and 4 interviews with clinical service providers.

## 2.1 SECONDARY ANALYSIS OF EMIS SURVEY DATA

We conducted a secondary analysis of drug use data collected as part of the European MSM Internet Survey (The EMIS Network, 2013) specific to Lambeth, Southwark and Lewisham. EMIS was a large-scale internet survey of MSM conducted in the summer of 2010. It took place in 38 countries across Europe and in 25 languages simultaneously. Men were recruited primarily via online gay social and sexual networking sites, such as gaydar.co.uk, gayromeo.com and manhunt.com, but also with the support of hundreds of HIV and gay men’s charities across Europe (for a full description of EMIS methods see Weatherburn *et al*, 2013).

With a total sample of over 174,000 MSM, EMIS is the largest survey of MSM ever undertaken anywhere in the world. A total of 15,423 were resident in England at the time of completion, with 3,837 in London and 1142 resident in LSL. Responses to survey questions that related to use of drugs and use of gay social or commercial spaces were compared between LSL residents and residents in the rest of England. Relevant survey responses were also compared according to key demographic characteristics.

## 2.2 QUALITATIVE INTERVIEWS

Starting in early October 2013, we undertook 30 face-to-face interviews with gay or bisexual men from across LSL. To be eligible to take part they had to be over the age of 18, have used crystal meth, GHB/GBL or mephedrone during sex within the previous 12 months and be resident in either Lambeth, Southwark or Lewisham. Men were recruited by a number of mechanisms, including: online promotion via social networking apps that specifically cater for gay men; paid promotion in a London gay-scene print magazine with a large readership; and distribution of specially designed business cards that promoted the study and directed people to a dedicated webpage

([www.chemsexstudy.com](http://www.chemsexstudy.com)), which contained further information about how to take part. These business cards were distributed by a number of health and social care providers across Lambeth, Southwark and Lewisham, as well as handed out in a number of bars and other social spaces that cater for gay men in the boroughs. We sought, as far as possible, to balance the sample of participants according to HIV status, ethnicity and borough of residence. Key characteristics of the final sample can be seen in **TABLE 2.1** below. All interview participants described themselves as gay.

**TABLE 2.1** *Key qualitative interview sample characteristics*

<b>HIV testing history</b>	<b>N</b>	<b>Age</b>	<b>N</b>
Diagnosed HIV positive	13	Mean	36
Last test negative	17	Range	21-53
<b>Borough of residence</b>	<b>N</b>	<b>Ethnicity</b>	<b>N</b>
Lambeth	14	White British	16
Southwark	11	White Irish	3
Lewisham	5	White Other	8
		Black Caribbean	1
		Other	2



Interviews took place either at the Sigma Research offices at the London School of Hygiene & Tropical Medicine, or at the homes of participants. They lasted between one and two hours and explored, in detail:

- men's sexual history and current sexual behaviour;
- drug use and history of drug taking;
- motivations for using drugs during sex;
- perceived social norms surrounding chemsex;
- the impact of drugs on sexual practice and sexual pleasure;

- harms relating to chemsex they had personally experienced or witnessed in others;
- and experiences of managing their drug use and/or seeking help.

All interviews were digitally recorded and transcribed verbatim. Data was subjected to a rigorous, inductive thematic analysis (Braun & Clarke, 2006), aided by qualitative analysis software, NVIVO.

---

## 2.3 FOCUS GROUPS WITH MEMBERS OF LOCAL GAY COMMUNITY

In order to understand perceived community norms relating to chemsex, we convened two focus groups with gay and bisexual men resident in Lambeth, Southwark and Lewisham. These men were recruited via social media, e-newsletters distributed by community based organisations that cater for gay men, and some had volunteered to take part in interviews after the quota of 30 participants had been met. Most of those who took part had experience of using drugs within the previous 12 months, although this was not an essential criteria for inclusion. Of the 12 men who took part in total, one had

diagnosed HIV while 11 had last tested negative. They varied in age from 25 to 53 (mean = 38) and all were of white ethnicity (however seven were non-British). Nine men were resident in Lambeth, two in Southwark and one in Lewisham and all described themselves as gay. Discussions within these groups centred on perceptions of drug use on the gay scene in London (historically and currently), perceptions and understandings of chemsex, perceived harms associated with chemsex, and perceptions of services (existing and potential) to meet the needs of gay men in South London.

---

## 2.4 FOCUS GROUP & INTERVIEWS WITH COMMUNITY AND CLINICAL SERVICE PROVIDERS

In mid-November 2013 a focus group was convened with staff and volunteers from community based organisations that work to support the sexual health and well-being needs of gay men in Lambeth, Southwark and Lewisham. A total of 11 people took part, representing 4 different organisations and a range of job roles, from counsellors and mentors, to service managers. Discussion centred on experience of supporting gay and bisexual men in relation to their drug use, perceptions on changing drug use trends among the gay community, changes in service delivery in response to the issue of chemsex, and perceived service development need.

Four brief interviews (of between 30 and 45 minutes) were also conducted with clinical service providers from each of the boroughs. These were a sexual health consultant, a lead health advisor and two specialist nurses. Discussion mirrored the community-based service providers' focus group.

The clinical and community provider focus groups and interviews helped to shape the content of the interviews, framed priorities for analysis and contributed to the recommendations outlined in chapter 9, however the data collected within them does not feature heavily in this report.

# 3. DRUG USE AMONG MSM LIVING IN LAMBETH, SOUTHWARK AND LEWISHAM: SURVEY DATA FROM EMIS

This chapter provides a large-scale quantitative context within which to consider the detailed findings from the qualitative face-to-face interviews. It uses data from a large scale survey and compares drug use among MSM living in LSL with those living elsewhere in England. The survey sample is non-representative and, given the recruitment methods, the levels of drug use should be considered upper estimates for all MSM living in LSL. However, because the survey used the same recruitment methods throughout the country, the comparisons between men in LSL and those elsewhere are likely to be valid. The chapter begins by describing the EMIS sample for LSL as the demographic characteristics, followed by survey items relating to history of injection drug use. It then details prevalence and recency of drug use, including variation by age and HIV testing history and associations with use of gay social and sexual settings.

### 3.1 THE EMIS SAMPLE

The European Men-who-have-sex-with-men Internet Survey (EMIS) was an anonymous, self-administered online survey conducted simultaneously in 25 languages across 38 countries in Europe. The survey was open during June, July and August 2010. Respondents were recruited through 230 social and community websites for MSM. Typical completion time was 20 minutes. No financial incentives were given and no IP addresses were collected. The questionnaire is available at [www.emis-project.eu](http://www.emis-project.eu). A detailed account of the methods can be found elsewhere (Weatherburn *et al*, 2013).

EMIS polled 174,209 MSM living in Europe, of which 15,423 lived in England. As with all national surveys of MSM, more respondents indicated that they lived in Lambeth than any other borough in England. Southwark was the third most populous borough (after Manchester)

and Lewisham the 16th most populous. The number of men living in each borough was:

<b>Lambeth</b>	603 men
<b>Southwark</b>	357 men
<b>Lewisham</b>	182 men

Therefore, the EMIS database includes 1142 men living in LSL. This was 22.8% of the men living in London and 8.3% of those living in England. These data suggest LSL is home to more homosexually active men than any other three coterminous local authority areas in England. In the following sections we compare men living in LSL with men living in the rest of London and those living elsewhere in England. The most common sources of recruitment for men living in LSL were websites Gaydar (33.3%), Gay Romeo (23.6%) and Manhunt (17.2%).

---

### 3.2 SAMPLE DEMOGRAPHIC CHARACTERISTICS

The mean age of men living in LSL was 36.6 years (median 36 years, range 17-76). This was not significantly different to the rest of London or the rest of England. However the standard deviation in LSL was smaller at 9.5 years compared with 11.2 in the rest of London and 12.8 in the rest of England, suggesting both fewer younger and fewer older men in LSL than elsewhere (i.e. men in LSL are more 'bunched' into middle of the age range).

One in five (19.7%) of the men in LSL were living with diagnosed HIV infection, compared with 13.7% in the rest of London and 8.4% in the rest of England. EMIS disproportionately recruited men with diagnosed HIV

infection (Marcus *et al*, 2012), so we know these figures are overestimates for the population. However, the differences confirm a very high prevalence of HIV among MSM in LSL compared with elsewhere in England and in Europe more broadly.

A total of 11.8% of the men in LSL completed the survey in a language other than English. This was the same proportion as the rest of London (11.9%), which is much higher than the rest of England (4.5%). Men in LSL chose 18 other languages to participate, the most common being Spanish (2.4%, 27 men), German (1.8%, 21 men), Italian (1.8%, 20 men) and French (1.2%, 14 men).

### 3.3 INJECTING DRUG USE

EMIS asked two questions about injecting drugs.

**TABLE 3.1** *Injection of anabolic steroids among MSM in LSL %*

Have you ever injected anabolic steroids (testosterone)?	LSL N = 1136	Rest of London N = 3837	Rest of England N = 8678
No, never	91.8	95.2	98.3
Yes, more than 12 months ago	4.5	2.5	0.9
Yes, in the last 12 months	3.7	2.3	0.8

8.2% of LSL men had ever injected steroids, and 3.7% had in the last year. Both measures are higher in LSL than elsewhere in London and much higher than in the rest of the UK.

**TABLE 3.2** *Injection of drugs other than anabolic steroids among MSM in LSL %*

Have you ever injected any drug other than anabolic steroids or medicines?	LSL N = 1134	Rest of London N = 3826	Rest of England N = 8655
No, never	94.1	95.2	97.8
Yes, more than 12 months ago	2.4	2.15	1.1
Yes, in the last 12 months	3.5	2.7	1.1

5.9% of LSL men had ever injected drugs other than steroids or medicines, and 3.5% had done so in the last year. This was only slightly higher than the rest of London but much higher than the rest of England.

Men in LSL (as elsewhere) who had injected drugs were much more likely to be concerned about their drug use (19.4% were) than men who had not injected drugs. However, the majority (80.6%) of men who had injected drugs in the last 12 months were not concerned about their drug use.

### 3.4 REGENCY OF DRUG USE BY MEN IN LSL

Men were offered a list of 16 drugs and for each they were asked for the last time they had used each of them. The mean number of different drugs (not including alcohol or tobacco) used by men resident in LSL was 2.8, compared with 2.1 in the rest of London and 1.3 in the rest of England. This suggests a high level of poly-drug use in LSL residents compared with elsewhere.

The following table shows the proportion of men living in LSL who used each of the drugs within a range of time frames prior to completing the survey (sample size varies due to missing data). The drugs are ordered as they were asked in the survey. Common chemsex drugs are highlighted in green.

**TABLE 3.3** Recency of drug use among MSM in LSL %

Drug used within the last:	Alcohol N = 1140	Tobacco N = 1136	Poppers N = 1136	Viagra N = 1135	Sedatives N = 1132	Cannabis N = 1132	Ecstasy N = 1134	Amphetamine N = 1121
24 hrs	50.9	30.8	8.8	3.8	1.9	5.7	0.5	0.0
7 days	34.0	7.1	15.3	10.7	3.0	6.4	3.1	0.2
4 wks	8.2	5.5	14.1	10.8	3.3	7.4	8.1	1.2
6 mths	2.7	4.6	13.0	9.6	5.5	10.4	11.1	3.6
12 mths	1.1	4.0	7.7	5.2	3.8	8.8	8.7	4.9
1-5 years	0.9	9.1	12.2	10.1	7.4	13.5	13.1	14.1
>5 years	1.1	12.1	9.4	2.9	6.4	14.1	9.7	17.9
Never	1.1	26.8	19.4	46.8	68.6	33.6	45.6	58.2
Drug used within the last:	Crystal meth N = 1133	Heroin N = 1134	Mephadrone N = 1135	GHB/GBL N = 1124	Ketamine N = 1132	LSD N = 1123	Cocaine N = 1130	Crack cocaine N = 1130
24 hrs	0.6	0.0	0.6	1.2	1.2	0.0	1.9	0.0
7 days	1.6	0.1	3.6	4.1	3.4	0.3	5.7	0.0
4 wks	2.7	0.0	6.0	5.2	4.9	0.4	10.4	0.2
6 mths	5.5	0.2	12.8	5.3	9.4	1.3	11.5	0.3
12 mths	3.2	0.1	3.7	4.3	6.7	1.9	8.2	1.2
1-5 years	6.4	0.8	0.4	7.4	11.5	6.6	11.4	2.1
>5 years	4.1	3.2	0.1	3.1	4.7	18.9	6.9	2.6
Never	75.9	95.7	72.8	69.4	58.1	70.7	44.0	93.7

The following chart shows this data graphically. The drugs are ordered (right to left) by the proportion that had used the drug in the last 12 months.

Alcohol use was almost universal with 96.9% having used in the last 12 months and 50.9% having used in the last 24 hours. Cocaine use was almost as common as cannabis use: 66.4% had ever use cannabis, 38.7% had done so in

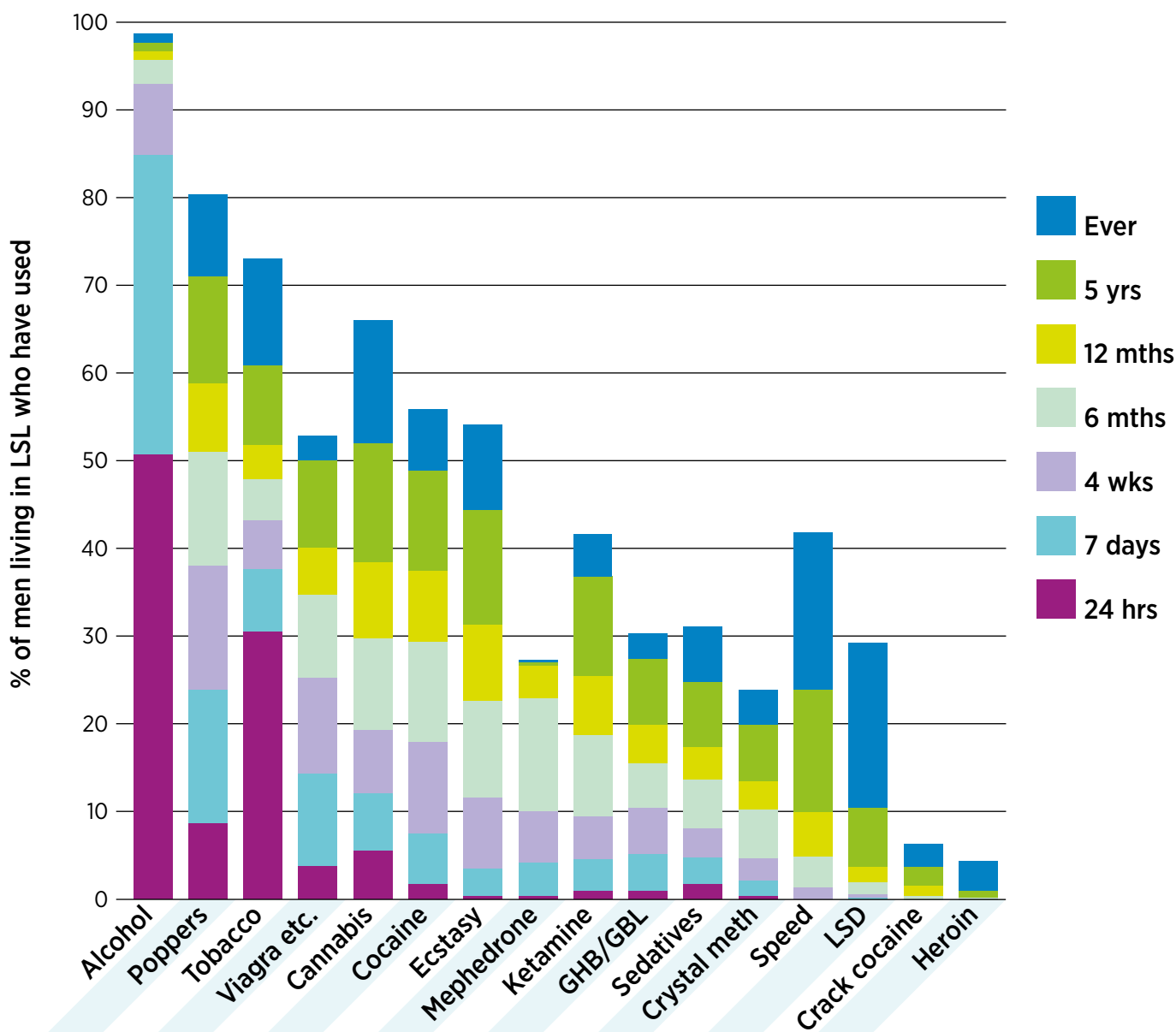
the last year and 19.5% had done so in the last 4 weeks; 56.0% had ever used cocaine, 37.7% had done so in the last year and 18.0% had done so in the last 4 weeks.

These data indicate that, when compared to the use of other substances, the use of key chemsex drugs was relatively low. However, almost all mephedrone use was recent use: 98.2% of men who had ever used it had

used it in the last 12 months. This drug became legally available on the internet in 2007/8, the survey took place

in summer 2010 and the drug was made illegal in the UK at the end of that year.

**FIGURE 3.1** Recency of drug use for sixteen named drugs, by MSM living in LSL



The use of crystal meth appears to be slowly increasing rather than rising exponentially. In 2007 a community survey of MSM in London estimated that 7.8% had used crystal meth in the last year (Bonell *et al*, 2010). In this 2010 survey the figure was 8.7%. Although not the most commonly used drug, crystal meth is associated with a high likelihood of harm to users (Nutt *et al*, 2010). GHB/GBL was more commonly used than crystal meth

in all time frames. Notably, 5.3% had used in the last seven days.

Two of the drugs, heroin and crack cocaine, were very rarely used: 4.3% had ever used heroin and 0.4% had done so in the last 12 months; 6.3% had ever used crack cocaine and 0.2% had done so in the last 12 months.

### 3.5 DRUG USE IN LSL COMPARED WITH ELSEWHERE

The following table shows the proportion of men in each area who used each drug in the last four weeks. It also shows the odds of man in LSL using the drug if the

odds of a man living elsewhere using it is 1.0 (unity).<sup>1</sup> Items displayed in bold indicate statistically significant differences.

**TABLE 3.4** Drug use among MSM in LSL compared to elsewhere

	Proportion of men who used drugs in the last 4 weeks			Odds ratio (and 95% confidence interval <sup>2</sup> ) for drug use in last 4 weeks (controlled for age and HIV status) by men living in LSL compared with men living ...	
	LSL	Elsewhere in London	Elsewhere in England	... elsewhere in London	... elsewhere in England
Alcohol	93.2	90.6	87.6	<b>1.43 (1.11-1.85)</b>	<b>1.89 (1.48-2.41)</b>
Tobacco	43.5	40.0	38.7	<b>1.16 (1.02-1.33)</b>	<b>1.22 (1.08-1.39)</b>
Poppers	38.2	33.3	26.9	<b>1.23 (1.07-1.41)</b>	<b>1.56 (1.37-1.78)</b>
Sedatives	8.2	6.2	3.8	<b>1.35 (1.05-1.73)</b>	<b>2.19 (1.72-2.79)</b>
Cannabis	19.5	15.9	10.5	<b>1.28 (1.08-1.52)</b>	<b>2.02 (1.72-2.38)</b>
Ecstasy	11.7	7.1	4.1	<b>1.72 (1.38-2.15)</b>	<b>2.96 (2.40-3.67)</b>
Speed	1.3	1.4	1.7	0.95 (0.53-1.68)	0.82 (0.48-1.41)
Crystal meth	4.9	2.9	0.7	<b>1.74 (1.25-2.42)</b>	<b>8.34 (5.69-12.21)</b>
Heroin	0.1	0.2	0.3	0.37 (0.05-3.00)	0.32 (0.04-2.39)
Mephedrone	10.2	5.2	2.9	<b>2.01 (1.63-2.64)</b>	<b>3.83 (3.03-4.84)</b>
GHB/GBL	10.5	5.5	1.6	<b>2.00 (1.58-2.53)</b>	<b>6.94 (5.38-8.97)</b>
Ketamine	9.6	5.9	3.8	<b>1.65 (1.30-2.10)</b>	<b>2.58 (2.05-3.24)</b>
LSD	0.6	0.4	0.3	1.42 (0.59-3.43)	2.24 (0.96-5.23)
Cocaine	18.0	11.0	4.8	<b>1.76 (1.47-2.12)</b>	<b>4.13 (3.43-4.96)</b>

Three rarely used drugs – speed, heroin, LSD – showed no significant difference in the proportion of men using in the last four weeks between those living in LSL and those living elsewhere. All of the other 12 drugs were significantly more commonly used by men living in LSL compared with men living elsewhere in London and elsewhere in England.

It is particularly notable that men living in LSL were twice as likely as men elsewhere in London to use GHB/GBL (10.5% vs. 5.5%) and mephedrone (10.2% vs. 5.2%). Compared to men elsewhere in England, men in LSL were four times more likely to use cocaine (18.0% vs. 4.8%) and mephedrone (10.2% vs. 2.9%); seven times more likely to use GHB/GBL (10.5% vs. 1.6%); and eight times more likely to use crystal meth (4.9% vs. 0.7%).

<sup>1</sup> The odds ratio is a measure of how much more likely an event or characteristic is in one group compared with another. An odds ratio of 1 means the event or characteristic is equally likely in both groups. For example, the odds of a man living in LSL having used tobacco in the last 4 weeks are 43.5/56.5 = 0.77 (the proportion who did use divided by the proportion who did not use). The odds of a man elsewhere in England having used tobacco are 38.7/61.3 = 0.63. The ratio of these

two odds is 0.77/0.63 = 1.22. So men in LSL are 1.22 times more likely to have used tobacco compared with men living elsewhere in England.

<sup>2</sup> The 95% confidence interval is the range within which we are 95% sure the real value lies in the population given the number of men we surveyed. If the range includes 1 we cannot be confident that the event is more or less common in one group compared with the other.

## 3.6 VARIATION IN DRUG BEHAVIOURS AND NEEDS ACROSS DEMOGRAPHIC GROUPS

The following sections look at differences in drug use behaviours and needs across age, HIV testing history and language used for survey completion.

### 3.6.1 Age

The following table shows the proportions of four age groups who had used each of the drugs in the last four weeks, experience of drug injecting and concern about drug use. The drugs have been ordered by their overall

commonality of use. For the indicators that varied significantly by age, the age group with the highest level of use (or concern) is in bold.

**TABLE 3.5** Variation in drug use by age among MSM in LSL %

Proportion of men who used drugs in the last 4 weeks	All men living in LSL N = 1142	By age group (MSM living in LSL) %				p for Chi-squared*
		under 30 years N = 298	30-39 years N = 439	40-49 years N = 290	50 years and over N = 115	
Alcohol	93.2	<b>96.6</b>	92.5	90.7	93.0	.033
Tobacco	43.5	<b>49.7</b>	40.0	45.3	36.0	.021
Poppers	38.2	30.3	39.2	<b>43.3</b>	41.7	.008
Cannabis	19.5	19.6	18.9	22.4	14.3	.307
Cocaine	18.0	14.9	<b>21.5</b>	20.4	6.2	.001
Ecstasy	11.7	12.1	<b>14.0</b>	10.8	4.4	.038
GHB/GBL	10.5	8.6	<b>13.2</b>	11.8	1.8	.003
Mephedrone	10.2	9.5	<b>13.3</b>	9.7	1.8	.004
Ketamine	9.6	8.5	9.7	11.4	7.9	.591
Sedatives	8.2	5.1	<b>10.8</b>	9.1	4.4	.016
Crystal meth	4.9	4.4	4.6	6.9	2.6	.262
Speed	1.3	1.4	1.9	1.1	0.0	.454
LSD	0.6	1.0	0.5	0.7	0.0	.644
Heroin	0.1	0.0	0.2	0.0	0.0	.659
Injected steroids last 12 months	3.7	4.4	3.4	4.5	0.9	.307
Injected other drugs last 12 months	3.5	1.7	3.0	<b>5.9</b>	4.4	.041
Concerned about drug use	10.4	9.4	11.7	11.7	4.4	.108

\*Chi-square is a test that ascertains statistical differences between groups.

A p value of less than 0.05 indicates a statistically significant difference



Seven of the 16 drugs did not show a significant difference across age including commonly used cannabis, moderately commonly used ketamine and the five less commonly used drugs (crystal meth, speed, LSD, crack cocaine and heroin). The other 9 drugs showed significant differences in commonality of use across the age range. The two legal drugs (alcohol and tobacco) were most commonly used by men under 30. Poppers

and especially Viagra were used by older men. The remaining five drugs (cocaine, ecstasy, GHB/GBL, mephedrone and sedatives) were most commonly used by men in their 30s.

Injecting drugs other than steroids (or prescription drugs) was increasingly common with increasing age, peaking among men in their 40s.

### 3.6.2 HIV testing history

The following table shows the differences by HIV testing history in the proportions of men who had used each of the drugs in the last four weeks, experience of drug injecting and concern about drug use. The drugs have

been ordered by their overall commonality of use. For the indicators that varied by testing history, the group with the highest level of use (or concern) is in bold.

**TABLE 3.6** Variation in drug use by HIV testing history among MSM living in LSL %

Proportion of men who used drugs in the last 4 weeks	All men living in LSL N = 1135	By HIV testing history (men living in LSL)			p for Chi-squared
		Never tested N = 132	Tested positive N = 224	Last test negative N = 779	
Alcohol	93.3	91.7	92.0	94.0	.422
Tobacco	43.7	44.7	<b>52.3</b>	41.0	.012
Poppers	38.1	17.4	<b>55.4</b>	36.6	<.001
Cannabis	19.5	10.7	<b>30.3</b>	17.9	<.001
Cocaine	17.9	6.8	<b>34.1</b>	15.2	<.001
Ecstasy	11.7	4.6	<b>21.7</b>	10.1	<.001
GHB/GBL	10.5	1.5	<b>25.8</b>	7.6	<.001
Mephedrone	10.1	3.0	<b>22.5</b>	7.8	<.001
Ketamine	9.5	1.5	<b>22.6</b>	7.1	<.001
Sedatives	8.2	3.8	<b>14.9</b>	7.0	<.001
Crystal meth	4.9	0.0	<b>17.2</b>	2.2	<.001
Speed	1.3	0.0	<b>3.3</b>	1.0	.016
LSD	0.6	0.0	0.0	0.9	.201
Heroin	0.1	0.0	0.5	0.0	.130
Injected steroids last 12 months	3.7	2.3	<b>7.7</b>	2.8	.002
Injected other drugs last 12 months	3.5	0.8	<b>11.3</b>	1.7	<.001
Concerned about drug use	10.4	3.8	<b>16.1</b>	9.9	.001

The most common drug (alcohol) and the three least commonly used (LSD, crack and heroin) did not significantly vary by HIV testing history. All other drugs were significantly more common among men with diagnosed HIV, as were injecting (steroids and other drugs) and concern about drug use. The only indicator higher among not-positive men was alcohol concern.

It is notable that two thirds (69%, 38/55) of men in LSL who used crystal meth in the last 4 weeks had diagnosed HIV and two thirds (64%, 25/39) of men in LSL who injected (non-steroid) drugs in the last 12 months had diagnosed HIV. [Crystal meth use and injecting drug use were very strongly but not exclusively associated with living with diagnosed HIV infection](#).

### 3.7 USE OF GAY SETTINGS

Men were asked how recently they had visited each of nine gay social settings in the country they live in. The following table shows the proportion of men living in LSL who had visited each setting within given time periods.

**TABLE 3.7** Use of gay social settings among MSM living in LSL %

Men living in LSL (N = 1142)	When was the last time you visited (cumulative proportion)						
	24 hours	7 days	4 weeks	6 months	12 months	5 years	Ever
A gay community centre, organisation or social group	2.5	7.7	13.7	21.0	26.8	36.6	45.5
A gay cafe, bar or pub	8.6	33.4	54.5	70.9	79.5	87.1	90.2
A gay disco or nightclub	3.6	18.3	36.0	53.8	64.1	77.8	86.1
A back room of a bar, gay sex club, a public gay sex party	1.1	5.1	11.5	20.8	27.1	38.5	46.2
A gay sex party in a private home	0.7	3.1	6.7	12.2	16.9	24.4	30.4
A gay sauna	1.2	5.8	13.6	25.8	33.9	46.7	54.1
A porn cinema	0.3	0.6	1.1	2.2	3.5	7.4	15.2
A cruising location where men meet for sex	3.4	10.4	18.0	25.9	32.4	43.6	54.1
Any website for gay and bisexual men	79.5	94.4	97.2	98.3	98.9	99.2	99.3

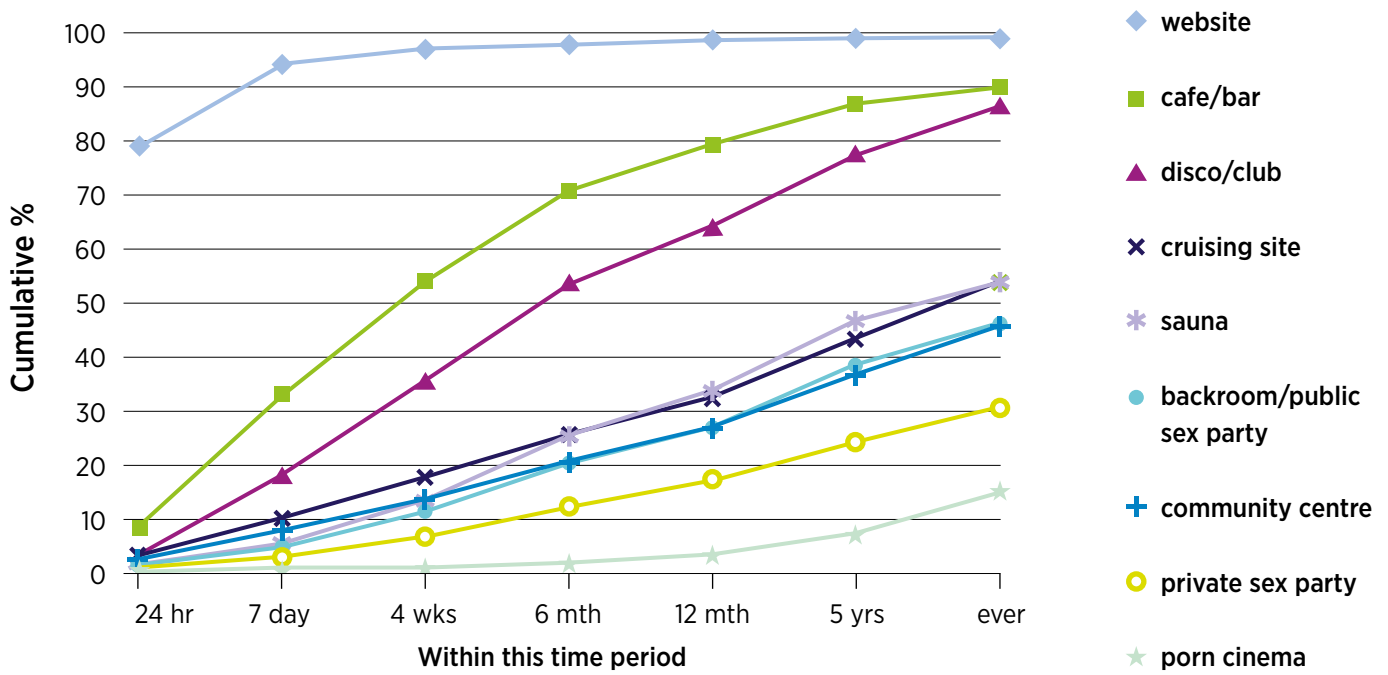
Since these men were all recruited and surveyed on the internet it is not surprising that gay websites are the most commonly visited setting, with 80% having visited a gay website within 24 hours prior to the survey and 94% within the last 7 days.

However, gay cafes/bars are also still very popular settings (with 33% having been in the last week and 55% in the last month) and disco/clubs (22% and 58% respectively). For both cafe/bars and disco/clubs, these

data suggest that there are not two distinct groups (for example on-scene, off-scene) whereby men either use venues or they do not. Rather they suggest that the majority of men use gay scene venues but with varying degrees of frequency.

Outdoor cruising sites were as popular as saunas and gay community centres and social groups were as popular as backrooms and sex clubs. The following figure shows the above data in a visual form.

**FIGURE 3.2** Cumulative recency of use of gay social settings by MSM in LSL



### 3.8 SETTING USE AND DRUG USE

In considering the association between setting use and drug use we have concentrated here on the four drugs currently causing most concern for gay men in LSL – crystal meth, mephedrone, GHB/GBL and ketamine. In

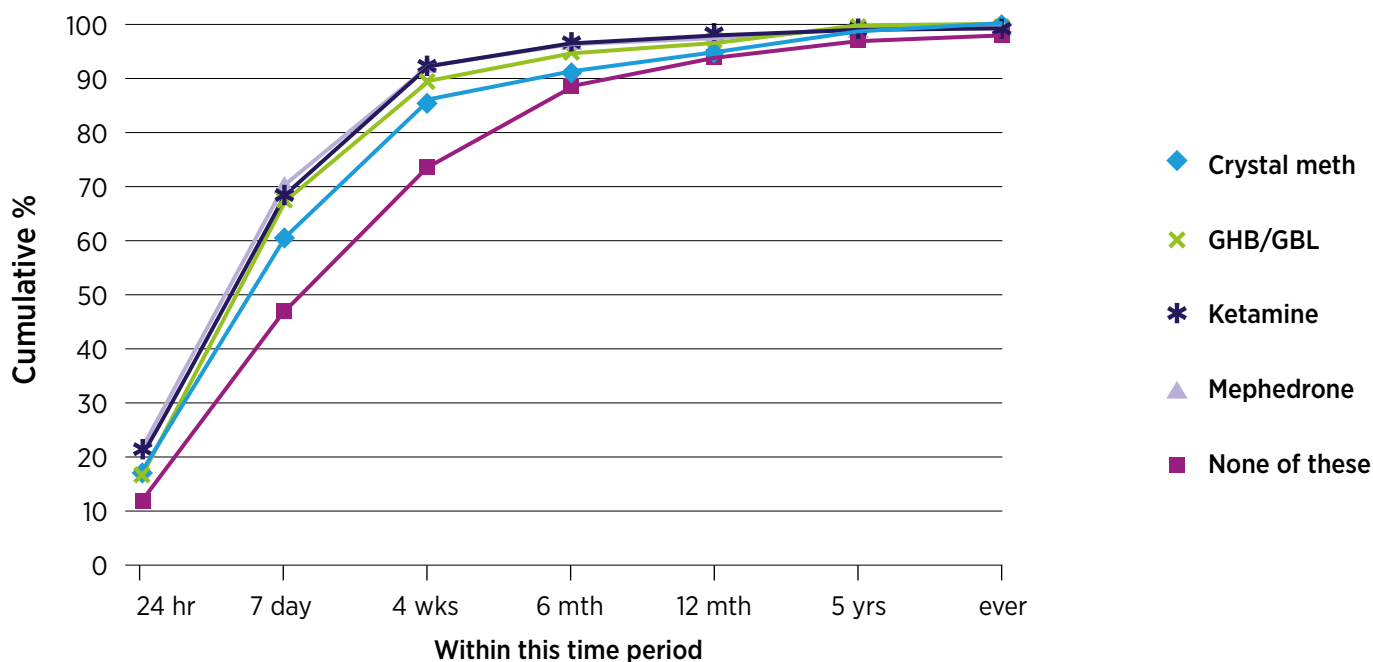
the following sections we look at how recently men using each of these four drugs have used four settings: gay cafés/bars/pubs; saunas; backrooms and sex-clubs; and sex parties at private homes.

#### 3.8.1 Gay café/bar/pub use and drug use

The following figure shows the cumulative proportion of men who had used a gay café, bar or pub within increasing time periods before the survey. Each line represents the group of men who had used that drug in the last four weeks, with a fifth line showing the group of men who had used none of these four drugs in the last four weeks. The four drug use groups are therefore not exclusive groups (since some men had used more than one of these drugs).

Although attendance at gay cafes, bars and pubs was common among all groups, it was more common among men who used each of the four drugs than it was among those who used none of these four drugs. So for example, 47% of men in LSL who had used none of these four drugs had been to a gay café/bar/pub in the last four weeks compared with 61% - 71% of those who had used these drugs.

**FIGURE 3.3** Cumulative recency of attending a gay cafe/bar/pub by use of different drugs in last 4 weeks

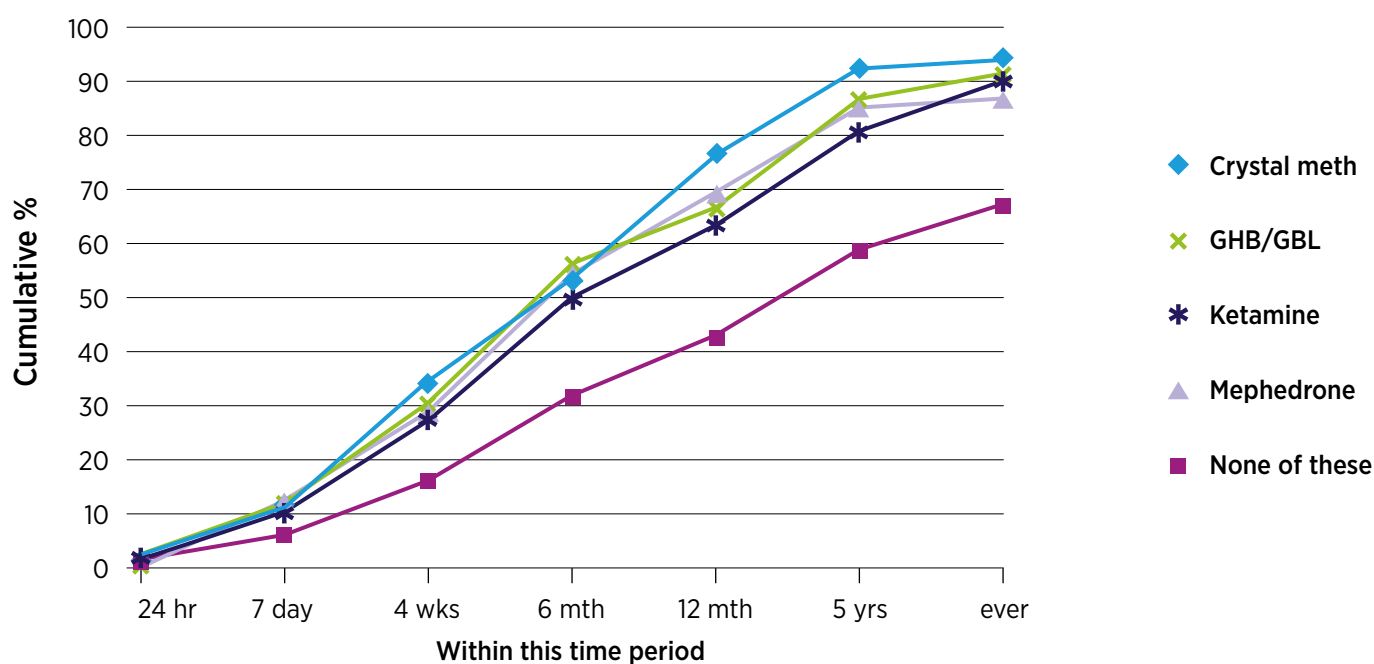


### 3.8.2 Saunas and drug use

The following figure shows how recently men living in LSL had been to a sauna, according to whether they had used each of four drugs in the past four weeks, or none of these four drugs.

The four drug-using groups are fairly closely bunched together and are some distance from the group who had used none of these drugs. This suggests that while sauna use is associated with all four of these drugs, no one drug in particular is associated with sauna use.

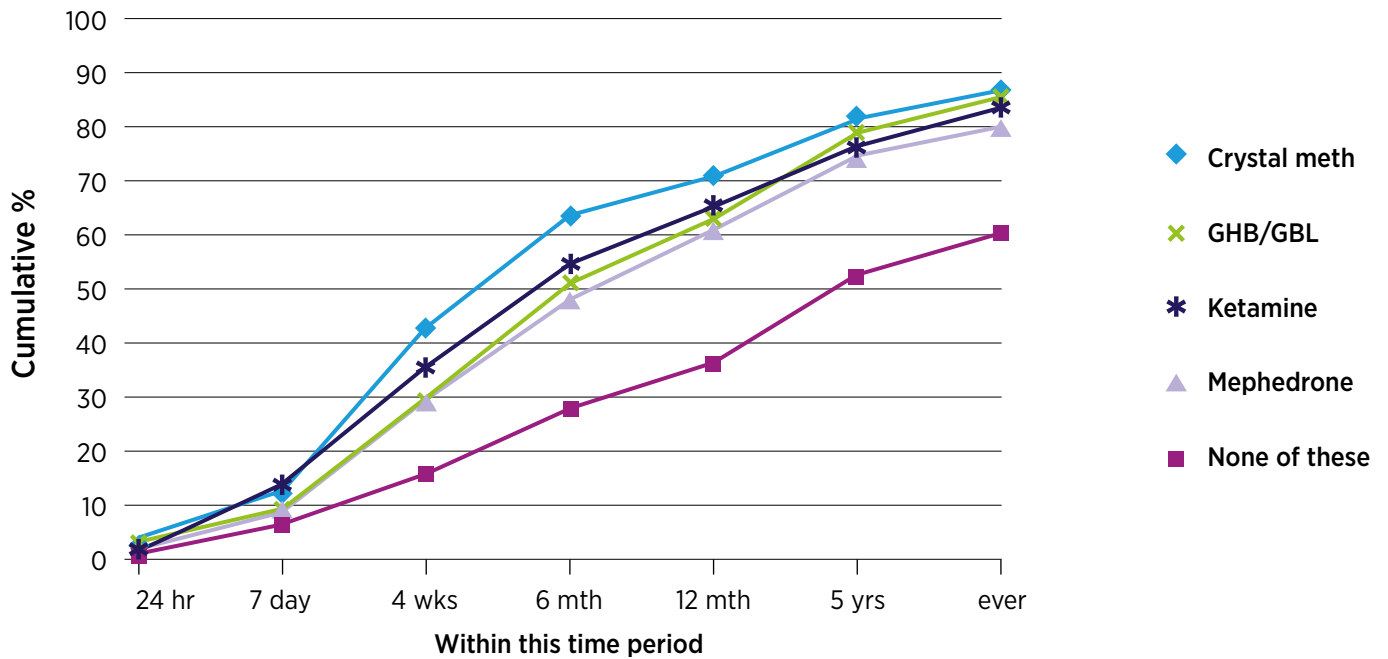
**FIGURE 3.4** Cumulative recency of attending a sauna by use of different drugs in last 4 weeks



### 3.8.3 Backrooms / sex clubs and drug use

The following figure shows how recently men had been to a backroom or sex club, according to whether they had used one of four drugs, or none of these four drugs

**FIGURE 3.5** Cumulative recency of attending a backroom/public sex party by use of different drugs in last 4 weeks

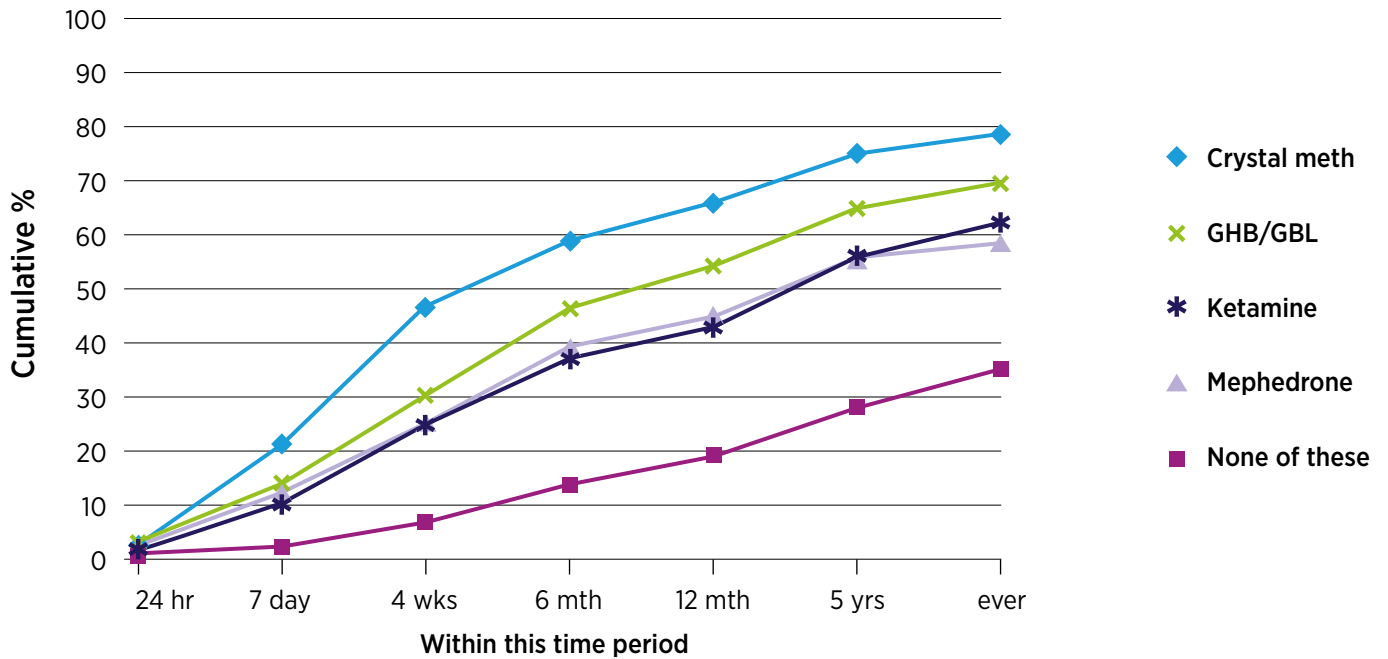


Backroom attendance was more recent for men who had used each of the four drugs, compared with men who had used none of the four drugs.

### 3.8.4 Private sex parties and drug use

The following graph shows how recently different groups of men had attended a private sex party.

**FIGURE 3.6** Cumulative recency of attending sex party in private home by use of different drugs in last 4 weeks



Men who had used crystal meth in the last four weeks were most likely to have been to a private sex party, with 21% having attended one in the past week and 46% in the last four weeks. This compares with 2% and 7% respectively among men who had not used these drugs.

These data suggest that crystal meth in particular is associated with sex at private house parties. However, crystal meth users were more likely to have recently used gay cafes, bars and pubs than they were to have attended a private sex party.

### 3.9 SUMMARY

- Alcohol is by far the most commonly used drug and is the drug the largest proportion of men are concerned about.
- LSL is a population centre of gay men, people living with HIV and recreational drug use. Drug use among gay men is higher here than any other region of England.
- Concern about alcohol and drug use is very common among gay men in LSL.
- Although injecting drugs is relatively uncommon among gay men in LSL, those who inject are in greater need of harm reduction services.
- Poly drug use is the norm with few drug users using only one drug (apart from cannabis).
- There are temporal trends in the commonality of drugs used. LSD and speed have declined as ketamine, GHB/GBL and crystal meth use have risen. Mephedrone use has recently and quickly risen.
- While most drugs are used at all ages, alcohol and tobacco are most common among men under 30, while poppers and Viagra are most common among men over 40. Men in their 30s are most likely to use illicit drugs.
- Illicit drug use, injecting and concern about drug use all significantly more common among men with diagnosed HIV.
- Men who use drugs are not a hidden population, they use the gay scene (pubs/cafes, clubs) more than men who do not use drugs.

# 4. THE CONTEXT OF CHEMSEX

This is the first of four chapters that describes the findings of the qualitative phase of the study. Chemsex is a diverse and complex phenomenon – a sexual behaviour in which a wide variety of men engage, at different times, at different points in their lives, in different spaces, with a range of drugs and with complex consequences. There is no set formula for chemsex – what behaviour men engage in and the reasons for their use of drugs in sex are specific to each individual.

In this and the following three chapters we describe key trends and themes relating to the personal and social context of chemsex, the impact they have on sexual pleasure and performance, their role in sexual risk behaviour, the harms that men experience and means by which they have sought to manage these harms.

Here we provide an overview of the drug using element of chemsex, considering the key drugs used and why, drug initiation narratives, favoured means of drug delivery, and the settings where chemsex typically occurs. We also describe the broader social context of chemsex, including perceived norms and community rationales for using drugs in sex. Also presented are three composite narratives of three fictional men engaging in chemsex in a variety of ways and with differing consequences.



## 4.1 DRUGS OF CHOICE FOR CHEMSEX

Participants in this study had to have used one or more of three key drugs – crystal methamphetamine (crystal meth or Tina), GHB/GBL (G), and mephedrone – either immediately before, or during sex with other men within the last 12 months. Use of other drugs was also discussed in the interviews, most commonly ketamine, ecstasy and cocaine, in order to get a rounded picture of men’s drug use. The majority of participants were experienced drug users. While many had a favourite or a “drug of choice” most had experience of several, or all, of these drugs. This section describes participants’ favourite drugs and their reasons for using them (and not using others).

Mephedrone use was almost universal among the participants. It was favoured by many for its relatively low price and reliable quality, especially in comparison to cocaine and ecstasy. Participants also reported that mephedrone was easy to source through dealers and through all the settings where chemsex commonly occurred.

*“I used to buy it when it first came on the market, 50 grams, £300, through the door, gave it to everyone I knew, I was like the Pied Piper of mephedrone, got everybody onto it, straight people, “Oh my God, this is amazing, £6 a gram”. But I’ve seen so many people become really hooked on it. [...] But because it’s so cheap and so – it’s just everywhere now.”*

[Aged 40, last tested HIV negative]

Many participants felt that mephedrone was so widely used on the commercial gay scene that it was inescapable. Some men felt that unlike Vauxhall, Soho had remained a gay commercial scene mainly driven by alcohol consumption but even this was changing now.

*“Mostly meph, it’s mostly mephedrone. It’s there, and the most common one. It just seems to be so cheap and available and I’ve noticed in the last few years it to be very normal to use mephedrone. When I first*

*started going out in London, drugs you wouldn’t see it so much in Soho, but now if you walk into anywhere in Soho and you walk past someone who smells of mephedrone and are completely off their face and maybe it’s just my memory, but I don’t remember Soho being like that a few years back.”*

[Aged 23, last tested HIV negative]

GHB/GBL was popular for many of the same reasons as mephedrone. It was considered very cheap and widely available and many men reported that it relaxed them, increased their confidence and made them “horny”. Like mephedrone, the majority of all participants had experience with GHB/GBL, and many used it alongside mephedrone, often in the same chemsex session.

*“Do you take mephedrone and G together; do you take them in combination?*

*Usually the G first, because that kind of like relaxes, so if you go into someone’s house, you know a shot of G at the start would be good just to relax and make you more comfortable, talkative, you know, and then after you do the mephedrone.”*

[Aged 34, diagnosed HIV positive]

GHB/GBL had a reputation as a more dangerous drug than mephedrone, principally because of the potential for over-dosing (see chapter 7.1). There was also less consensus among the participants of the utility of GHB/GBL in relation to sex – some felt it did not improve the sex they had, but they enjoyed using it when they wanted to relax and get to know someone, or in the context of “chill out” parties after clubbing. Others argued that sex was exceptional when under the influence of GHB/GBL. What is key here is that all the key drugs played different roles for different men, and at different points in their lives.

While the ease of over-dosing gave GHB/GBL a reputation as a dangerous drug, most participants

‘mephedrone was so widely used on the commercial gay scene that it was inescapable. Some men felt that unlike Vauxhall, Soho had remained a gay commercial scene mainly driven by alcohol consumption but even this was changing now.’

still used it. In comparison, crystal meth had both a reputation as the ultimate chemsex drug and as dangerous because, unlike mephedrone, it was widely assumed to be very addictive. Among users of crystal meth, many described it as their ideal chemsex drug. Alongside feelings of euphoria, it was reported to heighten sexual appetite and stamina (see chapter 5.2).

More so than any of the other chemsex drugs, crystal meth polarised views among the participants. One in five had never taken it, and vowed they never would. Among the others, some who had taken it would not buy it and only took it opportunistically. It was widely feared for its addictive qualities and its association with injecting drug use (slamming).

*“Crystal I’ve dabbled in. Usually I would buy a quarter at Christmas and it would fuel me through the Christmas and New Year parties [...] When my usual dealer that just did ketamine was away on holiday for a month he recommended this other guy. I went to him to get ketamine and he did other stuff and said, and he did Tina. I thought, bloody hell, I haven’t had that for ages so that started my slippery slope of me taking it and me taking it more often, I found that instead of being at the weekends it was every day and me*

*thinking, oh I’ll take some in the morning and all sorts of stupid stuff like that and then of course it leads to sex all the time.”*

[Aged 48, diagnosed HIV positive]

While these three drugs – mephedrone, GHB/ GBL and crystal meth – are central to most of the narratives about chemsex, other drugs were routinely discussed. Many describe using erection enhancing drugs to counter the effects of the above. Some described using a wide variety of other drugs especially ketamine, ecstasy and cocaine, although these had seemingly fallen out of fashion with the rise of mephedrone and GHB/GBL. There was also a widespread assumption that there had been a decline in the purity and strength of ecstasy and cocaine over the last decade.

If there is a fourth drug that is most closely allied to chemsex narratives it is ketamine, but its effects are substantially different from the main three drugs. Ketamine is a dissociative (a class of hallucinogen) which distorts perceptions of sight and sound and produces feelings of detachment and dissociation – from the environment and the self. In low doses ketamine is used as a club drug, or to improve the experience of receptive anal intercourse and fisting.

---

## 4.2 DRUG USE INITIATION NARRATIVES

The majority of participants had a history of recreational drug use prior to becoming involved in chemsex as it is described here. Many described having previously used club and dance drugs, especially ecstasy and/or amphetamines like speed. Indeed a large proportion of participants had, at some point during their lives, consumed most of the illicit drugs popular in the last few decades.

‘a large proportion of participants had, at some point during their lives, consumed most of the illicit drugs popular in the last few decades.’

The only drugs that were very rare in any man’s drug history were heroin and crack cocaine. While a very small number of participants had tried heroin out of curiosity, they almost universally looked down on these drugs as dangerously addictive. Some men viewed crystal meth with a similar fear and distaste but this perception was universal, or near universal, in relation to heroin and crack. Many men described using GHB/GBL, mephedrone and even crystal meth as a predictable and understandable next step in their drug use career. This was not a classic progression from softer to harder drugs and eventual addiction, as commonly depicted in the mainstream media, but something more akin to following a changing community norm (or a fashion), driven by price, availability and perceived quality. This is not to say there were no accounts of men taking to chemsex drugs with limited or no previous experience of other illicit substances, but these accounts were rare.

*“I was always anti-drugs, yeah, very much. Basically I used to fancy this guy very, very much. And when he came to my place and he said, “Oh, would you have some?” Because I fancy him I thought okay, so let’s have some to share together [...] So the first time which was, we snorted some mephedrone. We smoked some meth. And we had a bit of G, you know, it’s the kind of normal concoction of gay sex with them drugs.”*

[Aged 31, last tested HIV negative]

It is important to keep these accounts of sudden and unexpected induction into drug use in perspective. While they are dramatic they were not the norm. The norm for these men was a progression from other drugs (like ecstasy or cocaine) that were typically used for clubbing and dancing, and as a precursor to sex with new partners met whilst clubbing, towards drugs specifically taken to facilitate more satisfying sex, with other men taking the same or similar drugs.

## JORGE’S STORY

Jorge is 27 and moved to London from Colombia two years ago. He works as a barman in Soho. He started using mephedrone when he went to “chill outs” with friends after a night out. They sometimes would end up at a sauna as well and he would be offered mephedrone or GHB by other men. It’s usually around and plentiful; he never really buys it himself but is offered it by a lot of older guys. He doesn’t want to take crystal meth – it seems like a really dirty drug to him, especially if you inject it. He gets frustrated with men on apps asking him for drugs or wanting chemsex all the time as he doesn’t need to use drugs to enjoy sex and worries what the different drugs do to his body. He had really wanted to meet a boyfriend but it is difficult with the men on the apps who just

seem to want quick sex. He is concerned about HIV and almost always has safe sex. Very occasionally he gets carried away with the moment and has not checked that they are wearing a condom. Once he took too much GHB with a guy he met on an app and fell into a G sleep. When he woke up the guy was fucking him without a condom. Jorge was really freaked out, especially when a friend later told him he thought this guy was HIV positive. Fortunately the friend knew about PEP and went with him to access it straight away. The whole experience has been a bit of a wake-up call and he has been a little reluctant to take GHB again during sex. He’d prefer to have fewer drugs and to fall in love.

## 4.3 MEANS OF DRUG DELIVERY INCLUDING INJECTING

The key drugs used for chemsex can all be used in a variety of ways: crystal meth comes as coarse crystals that can be crushed and snorted or smoked, or mixed and injected; mephedrone is usually a powder and can be mixed with a drink, but is usually snorted or injected; and GHB/GBL is usually in liquid form to be mixed with a drink but can be powdered. Less popular means of administration include a “Booty bump” (mixing the powder with water and injecting it into the rectum with a needle-less syringe cartridge) or pushing powder or tablet into the rectum with a finger, penis or sex toy. It is absorbed quickly when rectally administered and may be less painful than snorting and avoids the tell-tale signs of nasal drug use such as a running nose. However, the crystals may damage the lining of the rectum or cause fissures, which may facilitate HIV transmission.

In the same way as the participants portrayed heroin and crack as “bad drugs”, which are substantially worse than any they were taking, so injecting (or slamming) was reviled and feared by many of the participants in the study. Two thirds of all participants had never injected and, among these, many were incredulous when they observed injecting occurring around them. These participants often conceived of injecting as ‘crossing a line’ from sex and drugs for recreation into addictive behaviour.

*“But not for you, injecting? So you haven’t done it yourself?  
Never, there’s just certain boundaries I have and that would be one of them. I don’t see the point. I think it’s incredibly dangerous. My friend, his new boyfriend,*

*he told him never to slam, he did and ended up in hospital for three days because I think – I don't even understand it but – why would you allow somebody off their head to inject in your arm, when they don't know what they're doing, to me that's lunacy.”*

[Aged 40, last tested HIV negative]

This antipathy to injecting drug use was strong for many participants, and was often based on the media portrayal of “heroin junkies”, living in squalor and stealing to feed their habit. Among slightly older men, who could recall the 1980s, injecting drug use was inexorably tied up with portrayals of shared needles, and associated with getting HIV, hepatitis and other blood-borne viruses. While many participants remained hostile to the idea of injecting, and avoided men that sought to “slam” when they encountered them at parties or on websites and apps, there was a widespread agreement that injecting was becoming more common on the chemsex scene.

*“I find now that a lot more people are injecting, I would say well, I mean three years ago when, two or three years ago like injecting was kind of hush, hush, you know people would be afraid to ask if you inject but now a lot more people are injecting.”*

[Aged 24, diagnosed HIV positive]

Even among the third of participants' that had injected, for many there remained an understanding that they had broken a taboo, or that they had crossed a boundary. For two men this had led to guilt and remorse and a conviction that they would not do it again. For others this taboo about injecting increased the transgressive nature of chemsex and served to increase the thrill. The contradiction expressed by the following participant was not unique – he felt disgusted by injecting until he tried it. Now he continues to inject even though he says himself it is “an absolutely stupid thing to do.”

*“When I first saw somebody do it [injecting] I was just like disgusted. I just thought they were crazy. Why on earth why would you do that to yourself? [...] Then*

suddenly I found myself doing it. I was disgusted and now I'm still disgusted at it.”

[Aged 23, last tested HIV negative]

Among participants that were not wholly averse to the notion of injecting drug use, some continued to avoid it because they were fearful of the process – several were frightened of needles – and others simply felt that it was too “aggressive” a means of drug administration for them, especially for an activity that was about recreation and fun. Others were curious about slamming but felt that given their “addictive personalities” they simply could not risk trying it, even once.

*“It's just a line I don't want to cross [...] I suppose I'm scared of it. I don't want to become dependent on drugs in any way, shape or form, let alone intravenously. And, I suppose, I'm scared of it. I don't – I wouldn't trust myself. I'd become addicted to it. It would be too good. The high would be too good. And, I suppose, I've seen – rightly, I've seen enough horror stories, predominantly from movies / films / TV, and that kind of stuff, that I just – I don't want it to happen to me.”*

[Aged 28, diagnosed HIV positive]

For those who had injected, this delivery mechanism was perceived to have several advantages. Some reported injecting to avoid the after effects of other means of delivery, such as damaged nasal passages or cold-like symptoms that could arise from snorting. Others injected mephedrone or crystal meth because it gave them a more intense, and / or longer lasting high. The intensity of the experience via injecting was an attraction to many and some saw it as a natural progression from other means of drug administration.

Among participants who injected there was a high level of understanding about safe injection practices. Clean needles were always utilised and were never shared, and maintaining proper precautions and cleanliness was almost universal in their accounts.

‘This antipathy to injecting drug use was strong for many participants, and was often based on the media portrayal of “heroin junkies”, living in squalor and stealing to feed their habit.’

*“Everyone I have ever slammed with has been very careful. You’re putting a foreign substance into your blood and if, if that’s going to be contaminated in any form or manner, then it’s going to make you ill. So you’ve got to be careful. Even if you’re high, by the time you’re going to slam meph again you’re down anyway so you’re in full control.”*

[Aged 53, diagnosed HIV positive]

A few had heard stories of needle sharing, including deliberate attempts to contract or transmit HIV (sometimes referred to as ‘bug-chasing’ or ‘gift-giving’) but none had directly witnessed this, nor were they closely associated with anyone who had.

For some, the act of injecting was so dangerous that they had to be in total control of the environment and

the process of injecting. However, others described a “thrill” in being injected by someone else, provided it was done properly. A small number of participants described being inducted into injection drug use by people said to be qualified doctors or nurses who were involved in chemsex and who showed them how to do it, or did it for them. This notion of being taught how to inject was common and several participants’ could identify trusted friends or dealers that had showed them how to do it. Others had learnt by trial and error how to slam, though most reported this was not straightforward and often led to adverse medical consequences and wasted drugs (see section 7.1). Seven of the nine men who said they injected drugs had diagnosed HIV, although it is not clear if injecting drug use preceded, or was subsequent to, their HIV diagnoses, or both.

---

## 4.4 MEANS OF ACQUIRING DRUGS

Participants’ means of acquiring drugs for chemsex were diverse. Dealers were relatively common but many men did not have a regular supplier. Instead they picked up the drugs they wanted as and when they needed them – via hook-ups arranged on geosocial sexual networking applications (henceforth referred to as sexual networking apps or apps) that cater specifically for gay men, in parties, in saunas and in clubs. Some relied on sexual partners and others reported never having bought drugs – or at least they reported buying them much less often than they had taken them.

Sharing of drugs varied according to the drug – given the very high price (and variable quality) of cocaine no one really expected that to be shared, and some felt the same way about crystal meth. However, with GHB/GBL and mephedrone which are relatively cheap, sharing was very common, both with friends and partners but also with relative strangers in parties, clubs and saunas. Men also described how sharing drugs helped to ensure there were on the same ‘level’ with sexual partners, which ultimately made sex more enjoyable.

Sharing drugs was sometimes reported to be part of a sexual exchange. Transactional sex for drugs was occasionally described by younger and more conventionally attractive participants.

*“No, no, no I don’t. Very ... no, I’ve never bought meph. Because I don’t have a dealer but now I’ve met this guy online I do know somewhere to buy it.”*

So you always rely on other people?

*Pretty much.*

So you find people online who have it?

*Well, I don’t go looking for people online that have it. People approach me and say, do you want to come over and slam and I’ll fuck you, and [I say] “okay, cool.”*

[Aged 24, diagnosed HIV positive]

Dealers did figure in the supply stories that at least half of participants told, but in a wide variety of ways. Some participants found it hard to distinguish between men they bought drugs from, men they used drugs with and others they counted as firm friends (which had consequences for those trying to manage or limit their drug use, as discussed further in chapter 8.4).

## DARREN'S STORY

Darren is 41. He has been using the gay scene since his early twenties when he first came to London from Derby. He has a lot of experience with using drugs recreationally, marijuana, acid, and ecstasy, cocaine, ketamine, mephedrone, GHB and crystal. He has used them all with friends for clubbing, which has a big part of his life. Occasionally he uses GHB or snorts ketamine when at clubs with a backrooms or at fetish clubs, especially if he's going to be fisted. He tested HIV positive 5 years ago and is on treatment with an undetectable viral load. He tends to prefer bareback sex with other HIV positive men and has few sexual boundaries. Almost every weekend he will end up at a "chill out", sometimes for a few hours

but more often than not for the whole weekend. His drugs of choice for sex are mephedrone and GHB. He injected mephedrone a couple of times but it really seems a bit of a step too far and he doesn't want to become addicted. He doesn't have many problems with mephedrone or GHB, although occasionally he has gone into a G-hole, but is usually disciplined about how much and how often he takes it. He carries his HIV drugs with him so he generally doesn't miss taking them even if he ends up staying out for the whole weekend. He hasn't got a partner at the moment and would like one, but he doesn't think that is likely to happen given the way he is currently meeting men.

## 4.5 SETTINGS FOR CHEMSEX

Chemsex is not defined by where it occurs, in that it can happen in a variety of settings from private homes to any commercial gay venue that allows sex on the premises (and some that do not). Amongst all these accounts of chemsex, the majority occurred in a private house, in a sauna or in a commercial sex on premises venue.

Since the release of the first gay geosocial networking application five years ago, they have become increasingly popular and more ubiquitous as a tool for meeting partners, especially in cities where the density of men is particularly high, like London. For those we interviewed, they were often a first-port-of call for men seeking sex, drugs or chemsex away from the commercial gay scene. In addition to their use for meeting a single partner (for chemsex or just sex) the smartphone apps were also a primary means of organising and advertising sex parties.

Sex parties varied in the types and volumes of drugs being taken, the extent to which the drug use was public or private, and the means of administration. Some men reported never having observed injecting in a party, but suspected it occurred behind locked doors, while others reported only being interested in parties where injecting was the norm. There was a close association between the sex party scene and clubs and saunas. Parties often occurred after clubs had closed and, while they could occur anywhere across the city, they were generally geographically clustered around the commercial gay

scene, especially clubs with a late license. Vauxhall was considered the centre of chemsex by many, largely because of the 24-hour opening of some clubs and saunas.

*"I've been to parties in Soho as well that – because the areas where people – the chill-outs happen, and sex parties – is Vauxhall, East London, Soho, and then sometimes Paddington and Earl's Court. There's quite – it's the same people messaging you from those places [...] The reason it's ground zero in Vauxhall is because of the 24-hour club culture there."*

[Aged 21, last tested HIV negative]

While having sex in the clubs was easily achieved, many men bemoaned the tight security and the increasing difficulty of getting drugs into the commercial premises. Some only took drugs prior to entry, for fear of having them confiscated, while others only carried drugs that they felt were easily concealed and administered.

Many participants considered saunas the ideal environment for chemsex because they are typically warm and steamy and the atmosphere is relaxed. While some men reported being robbed or sexually assaulted while "out of it" in a sauna (explored further in chapter 7.1), most felt it was safer than using drugs in a club environment, because others were more likely to help if you needed it. Others felt it was safer than going to the

homes of strangers, and were re-assured by the presence of staff, although recognised that some discretion around drug use was still required.

*“But to go back to what we are saying earlier about people meeting on [\*app name] and then going off to somebody’s apartment somewhere, you really don’t know if that person is a psycho, if that person is going to rob you whereas if you are actually in a sauna, you are surrounded by people, there are cameras. There is a certain personal safeness about that I think.”*

[Aged 50, last tested HIV negative]

While some men reported being searched on entry to a sauna, these searches were considered less common and less “forensic” than on entry into clubs. Also, many participants reported that drugs were readily available in the saunas, both free from potential sexual partners and for sale from dealers.

---

## 4.6 THE SOCIAL AND COMMUNITY CONTEXT OF CHEMSEX

During the interview, participants were asked to reflect on the role and prevalence of drugs on the gay scene in London, and the reasons why they believed some gay men chose to use drugs during sex. Estimates of drug prevalence differed wildly, with many men believing it to be ubiquitous and an ever present component of gay life.

*“What’s your perception of drug use among gay men in London more generally?  
Rampant. It’s just everywhere. I mean, even if you go to – you think – no, it’s everywhere. I mean I can’t think of anywhere I’ve not seen drugs being taken Yeah, that’s the reality.”*

[Aged 31, last tested HIV negative]

Some men suggested that upwards of 80 or 90% of gay men in London used drugs on a regular basis (which seems unlikely given the data presented in chapter 3.4) and reported seeing it across the demographic spectrum of gay men and in every imaginable social setting. While some recognised that there must be some gay men who do not use drugs, most men felt that drug use was entirely normal in all aspects of the gay scene. It is, of course, important to bear in mind that these men were specifically recruited because they use drugs and will likely have a different perception than those who do not. A perception of normality was a problem for men who had become concerned about their drug use (explored further in chapter 8) and who were trying to avoid temptation.

*“How normal it is to take drugs in London in the gay community?”*

*Extremely common, I think one of the big things which scares me at the moment is that I almost have this fear of how I am going to meet people who actually don’t. Because I mean the big thing for me is having to stay away from the drugs and people.”*

[Aged 24, last tested HIV negative]

Nearly everyone agreed that mephedrone and, to a lesser extent, GHB/GBL had displaced ecstasy and cocaine as the principal drugs of choice among gay men, a perception reinforced in community and clinical service provider discussions. Crystal meth use, although relatively common among men in this sample, was perceived to be somewhat lower among gay men more generally. It was commonly associated with men who are HIV positive and with men who seek out condomless sex. While the majority felt that drug use was the norm for all gay men, a small number recognised that their perception may be heavily influenced by their own social circle and a choice to spend time with other men that use drugs (for a variety of purposes).

*“It’s not very many people, I’d say overall I guess, I don’t know because you only ever see the people who go out and you only see the people who are high or whatever. So I suppose overall it’s quite a small amount but it’s a significant number of people [...] I don’t know, a few hundred to a thousand maybe.”*

[Aged 23, last tested HIV negative]

While some recognised that drug use did occur in other locations, the vast majority felt that chemsex was highest in South London. Men talked about Vauxhall being

a “Mecca” for drug use and chemsex, facilitated by a commercial gay scene where both sex and drugs are easily available. The very high number of gay men living in these areas was, of course, also seen as a contributing factor.

“Can you tell me a little bit about how you think gay men in general use drugs nowadays? What’s happening in London?  
*Well, South London, it’s a bit of a mess I think [...] Yeah, Kennington, Vauxhall, that area. Yeah, when I moved there you’d go on Grindr and any time of night, middle of the week, there would be people having sex parties and drugs and chemsex and stuff. Sex parties have been in other parts of London but at that time of night there’d be no one around, or people would be looking for safe, one-on-one sex. But, yeah, there’s a real change in those areas I guess because of the proximity to Vauxhall.*”

[Aged 38, last tested HIV negative]

The reasons why men felt drug use was so common among the gay community were diverse and resonate with personal rationales explored further in the following chapter. Most participants talked about drugs and chemsex not only being easily accessible but also highly visible. Social and sexual networking apps had made it easier to identify drugs for purchase and made it clear when chemsex parties were occurring in one’s geographical location.

“It’s because of [\*app name]; it’s because of [\* website name]. It’s because the amount of people using them is so high. And it’s like an infection – like it has been for the last year only small pockets of gay society doing drugs, and having sex with drugs. But because more and more people can get exposed to that now. Like before, in the 90s, if people were doing it, who is going to know about it? [...] But strangers can be introduced to it now through things like these apps very easily. It’s become desensitised.”

[Aged 21, last tested HIV negative]

Several men expressed their belief that such apps were contributing to a demise in the commercial clubbing scene. Apps meant they were no longer reliant on physical spaces to meet other men for sex, or to source drugs, but could do so from their own home.

“It started to become, “We’re paying twenty quid to get into a place. Why not have drugs at home with a sex party?” You know, this is the alternative; and we’ve got apps that can help facilitate that need and make it happen.”

[Aged 31, last tested HIV negative]

Some men felt that increased visibility and accessibility of drugs had facilitated a sense that drug use and chemsex is ‘fashionable’ and acceptable. A few went as far as to suggest that drug use is perceived as an intrinsic part of gay lifestyle; it’s something you’re supposed to do as a gay man, particularly one living in London.

## ROB’S STORY

Rob is 36 and works as a personal trainer. He is originally from Norfolk but has lived in London for 15 years. He has tried most drugs, except heroin, and finds slamming crystal incredibly intense. He uses clean injecting. He visits saunas during the week and at weekends can spend 12–18 hours going from one sex party to another. In a quiet week he will have sex with 6–8 men but it’s more like 20 or 30 on a busy week. He tested HIV positive 3 years ago and although he will bareback with men he thinks are HIV positive, he doesn’t always ask his sexual partners, but instead relies on subtle cues or signal from sexual partners. He tends to assume that many of the men he meets at parties are also HIV positive or they wouldn’t be

having bareback sex with guys they don’t really know. In the last 12 months he’s had shigella and crabs, as well as recurrent genital herpes. Sometimes he finds it hard to get an erection and crystal doesn’t help, but he uses Cialis or Viagra and it doesn’t matter so much when he is being fucked or fisted. He feels that taking drugs has allowed him to engage in harder sex and group sex. He has had two semi-psychotic episodes where he had had to go to the hospital to get something to bring him down because he hadn’t slept for days and was panicking. Rob hasn’t had sex without drugs for quite a few years now, but doesn’t feel addicted.



## 4.7 SUMMARY

- Mephedrone, GHB/GBL and crystal meth (in that order) were the most popular chemsex drugs, although cocaine and ketamine were also commonly used.
- The rise in use of mephedrone and GHB/GBL seems, at least in part, to be a result of the rising cost, poorer quality and reduced availability of ecstasy and cocaine.
- Most men were experienced drug users (particularly on the clubbing or dance scene) and had progressed to taking the key chemsex drugs over time. A few had been newly introduced to illicit drugs, usually by sexual partners.
- A third had recently injected crystal meth or mephedrone, feeling that it gave them a more intense and immediate high. In nearly all instances injecting was done with care and there was no evidence of needle-sharing.
- The majority of men were uncomfortable with the idea of injecting drugs, feeling that it suggested addiction or was a sign of chaotic lifestyle.
- Social and sexual networking apps, saunas and clubs were the main avenues for drug acquisition. There was some evidence of transactional sex for drugs.
- Chemsex occurs in a range of settings, but most commonly in private homes, in saunas or other sex-on-premises venues.
- South London was widely perceived as an area of particularly high prevalence of chemsex, facilitated by the presence of a large gay population and a large commercial gay scene.
- Social and sexual networking apps may have increased the visibility of drug use and chemsex, with concern raised that this might influence the broader acceptability of these behaviours.

# 5. THE IMPACT OF DRUGS ON SEXUAL PLEASURE AND SEXUAL PERFORMANCE

Drugs had diverse, complex and conflicting effects on the sex lives of the men we interviewed. They were used for a wide range of reasons, meeting varied needs at different points of time or in different contexts. While there were some differences in the effects that each drug brought about, to a large extent they were very similar, operating along a spectrum (i.e. some drugs provided a more intense, but similar, effect to others). Polydrug use within the same session was so common it was often difficult for men to describe the effect of each individual drug on their sex lives. While the use of drugs could be powerful and positive, facilitating a range of desired behaviours or feelings, they could also have a very negative impact on sexual enjoyment or performance. Often a benefit of using drugs in sex could develop into a problem if drugs were used to excess or if used in the wrong context.

This chapter begins by considering how drugs, on a general level, could enhance sexual self-confidence, before describing how they could also facilitate sexual desire or libido, intimacy or sexual connection and sense of sexual adventure. It concludes by examining how happy the men we interviewed were with their sex lives, what they aspired to for sexual satisfaction and how, for many, this stood in stark contrast to their current sexual behaviour.

## 5.1 FACILITATING SEXUAL CONFIDENCE

One of the most highly valued effects of using drugs during sex was their ability to boost an individual's sexual self-confidence and remove feelings of self-doubt. The majority of men we interviewed articulated insecurities, either current or historic, which had a significant and detrimental impact on their ability to have sex that was enjoyable. Often these insecurities stemmed from negative feelings of self-worth, the origin of which was generally complex and deep-seated. Concerns were expressed by about a third of participants relating to internalised homophobia, problems coping with an HIV diagnosis and/or guilt related to having or desiring gay sex.

*“I have never really been able to have sober gay sex and then I think eventually what happened was crystal meth and getting so out of control. There was then all the guilt about what I was doing on the drugs. I could not escape from this cycle of guilt around sex and the drugs and it just goes backwards and forwards.”*

[Aged 24, last tested HIV negative]

Nearly two thirds of men described issues relating to their body image, often feeling that they were not attractive or worthy of other men. A number described how social and sexual networking apps heightened their concerns about their body image and attractiveness by frequently presenting idealised images of male bodies, which are toned and muscular. While the mechanism by which it occurs is complex, drugs helped to remove or displace such anxieties when presented with sexual opportunities.

*“I think when I was using drugs I did not have body issues. I did not think, I am feeling a bit too fat or feeling that I do not really feel that attractive so it reduces inhibitions physically and psychologically in terms of having sex and with people you would not feel comfortable, like, having sex with normally.”*

[Aged 40, diagnosed HIV positive]

*“If you get rejected and you are on mephedrone it doesn't really matter. The club is full of other people. It has kind of, like, separated you from the reality of that sting.”*

Drugs also enhanced confidence by moderating the fear of rejection, or by ameliorating its effects. Men with low self-confidence or low self-esteem described how they frequently worried about whether other men would be sexually or romantically interested in them and that this sometimes acted as a barrier to them engaging men in conversation or sexual contact. Drugs, once again, served to remove this cognitive barrier and lessen the feelings of hurt if rejection did occur.

*“If you get rejected and you are on mephedrone it doesn't really matter. The club is full of other people. It has kind of, like, separated you from the reality of that sting.”*

[Aged 26, last tested HIV negative]

Several men also described concerns about being good at sex and felt that, without drugs, they lacked confidence in having sex. Given the emphasis that many men placed on satisfying their sexual partner as a core component of good sex, feelings of poor performance could be debilitating. Drugs could allow distancing from these worries and concerns and allow one to focus on the sexual situation and achieve more enjoyable sex.

*“It just frees your mind a little bit more actually to roll with it rather than the thousand and one different types of questions that pop into your head normally. It just reduces that to about ten. So therefore you are kind of in the moment a bit more.”*

[Aged 33, diagnosed HIV positive]

‘Many participants described how drugs could significantly increase sexual desire or libido, but at the same time diminish sexual performance. Erectile dysfunction under the influence of crystal meth and mephedrone was very widely reported, as was retarded ejaculation.’

## 5.2 INCREASING SEXUAL DESIRE AND LIBIDO

For all of the men we interviewed, drugs had the effect of increasing libido or sexual desire. This was almost instantaneous when injecting crystal meth or mephedrone. Most men reported that mephedrone and GHB/GBL made them feel aroused, with this effect even more pronounced among men who used crystal meth and/or injected drugs. More than a quarter of those we interviewed had experienced problems with their libido and felt that their sex drive was not as high as it once was, or as high as they would like. Drugs, by either chemical or placebo mechanisms (or both) worked to increase sexual desire and enabled sexual contact, which men knew from prior experience they very much enjoyed.

*“I don’t have a sex drive any longer. It’s one of the reasons why I started slamming chems because when I slam, I get horny.”*

[Aged 53, diagnosed HIV positive]

Some, however, described their increased sex drive under the influence of drugs in very emotive terms, suggesting that it was insatiable or overpowering, particularly when taking crystal meth.

*“But, so there’s that it just makes you feel horny. I can’t put it in to words. It’s just that everything feels more intense, you feel sluttier. You feel you want to fuck loads of people.”*

[Aged 40, last tested HIV negative]

In addition, the use of drugs could significantly enhance the sensation of sex, with men describing intense physical stimulation and heightened orgasms that they had never experienced when having sex sober. This was highly valued and explained why many men used drugs for all, or nearly all, of their sexual experiences.

*“It was the best sex I ever had [on mephedrone]. Really the best orgasm I’d had. I used to say it was like the heavens opened and it was like the light came down when I had an orgasm. Because it was that intense on drugs, it really was. I’ve never experienced that sober.”*

[Aged 21, last tested HIV negative]

However, several participants expressed concern that they now only felt aroused, or had a sufficiently high sex drive, when they were under the influence of drugs. A narrative of drug-dependency ran through several interviews, with men finding it hard to imagine sex without drugs anymore.

*“You had sex with that guy and you didn’t use any drugs? It was horrible.”*

It was horrible?

*Yeah I don’t know, I just think I’ve had too much chemsex. It’s just boring and just doesn’t feel right.”*

[Aged 36, diagnosed HIV positive]

Some participants really struggled to articulate the impact that drugs have on their sexual desire and sexual performance because they had not had sex without drugs (sober sex) for some considerable time. Being questioned about this was often challenging, perhaps demonstrating a lack of prior opportunity to discuss or reflect upon the role of drugs in their sex lives.

Many participants described how drugs could significantly increase sexual desire or libido, but at the same time diminish sexual performance. Erectile dysfunction under the influence of crystal meth and mephedrone was very widely reported, as was retarded ejaculation.

*“So it was making me very horny, but impotent [...] And the whole process of having to find it [crystal meth], buy it, do it, experience the feelings of it, trying to hook up with men, and then the frustration of knowing you can’t get an erection. And in the end, just sitting around watching porn, trying to get this out of your system. You can’t even masturbate, because you can’t get a hard on.”*

[Aged 48, last tested HIV negative]

It was very common for men to take medication to counteract erectile dysfunction arising from chemsex drugs, thus enabling sexual performance in a period of enhanced sexual desire. However, some lamented the loss of sexual climax with partners, feeling that ejaculation was a core component of enjoyable sex which often cannot be achieved when drugs have been used.

---

## 5.3 INTIMACY AND SEXUAL CONNECTION

Over two-thirds of the participants described how drugs were sometimes able to enhance the sense of connection they felt with their sexual partner. Several articulated very intense feelings of sexual intimacy and a sense that they were ‘on another level’ with their sexual partner. This stemmed from a feeling they were in touch with both their own senses and the desires of their partner.

*“It puts you so much in the moment, so I’m just talking about G in particular. It kind of makes me feel like I’m so much in that one moment and with those people and in that moment physically in a very sensual, passionate, physical way. Not in this abstract ethereal way, kind of all in my head. It’s not, I’m in my body. It puts me in my body. And that kind of reconnection with my own body that I think I just ignore so much when I’m not high. It’s that very physical reconnection that actually drives the horniness, that drives the fact that I don’t have to think about these things anymore.”*

[Aged 32, last tested HIV negative]

However, this effect was often hard to achieve and could be short-lived. Nearly all men talked of problems related to not being ‘on the same level’ with their sexual partners. If the other person had taken different drugs, or more drugs, then some reported it was difficult or impossible to achieve this connection. Some men also felt that drugs

distorted their view of real emotion and attraction – men with whom they shared an intense, cognitively-connected, sexual experience could appear cold or distant when the effects of the drugs wore off.

*“I think you do feel more connected with someone when you’re on drugs because you’re both on the same level and there’s that kind of passion there. But it’s not real. It’s a fake passion. That’s what I always remind myself – it’s synthetic. It’s not real.”*

[Aged 21, last tested HIV negative]

This emotional and intimate dimension of chemsex was a significant contributor to dependency, particularly when considering that sex within romantic or intimate relationships was desired by the majority of those we interviewed (see section 5.6).

However, sexual connection was not a key factor for all men, or even for some men at all times – others said that intimate sex just was not possible on drugs.

*“Taking crystal it makes me a bit more animalistic [...] it makes sex very kind of – not aggressive but instinctive. It’s like more raw, for want of a better word. I don’t think you have sensual sex on crystal.”*

[Aged 28, diagnosed HIV positive]

## 5.4 SEXUAL LONGEVITY AND PARTNER TURNOVER

Drugs very often facilitated sexual longevity, with men reporting being able to have sex for long periods of time without ejaculating, and/or being ready to have sex again very quickly after ejaculating. This effect was particularly pronounced among men using crystal meth, who reported that sexual sessions could last for many hours, or even days.

*“So for me and this guy, we would smoke it [crystal] together and literally just fuck him for 12 hours, non-stop and it was brilliant. It was just – you feel super human, he can take it and take it. You give it and give it.”*

[Aged 40, last tested HIV negative]

Around a third of men described recent or regular chemsex experiences that involved having sex with a large number of men, over the course of several days and in several different locations. Taking drugs throughout this period meant that not only were they kept awake with high levels of energy, but their sex drive remained enhanced and their desire to have sex was undiminished (even if sometimes they experience problems with sexual

performance).

The drugs facilitated high turnover of sexual partners by both enabling longer sexual performance, but also some men felt that drugs influenced who exactly they were willing to have sex with. Most participants mentioned that the physical appearance (perceived attractiveness) of men they were willing to have sex with was very different when their sexual desire was increased.

*“Within ten to fifteen minutes of taking it [mephedrone] the world is a prettier place, so everybody becomes more attractive. People have got bigger muscles, bigger penises, their legs are more powerful.”*

[Aged 50, last tested HIV negative]

Most of the participants celebrated the fact that they were able to have sex with lots of men while using drugs. However, a few had come to question whether this high turnover was helping them achieve sexual satisfaction, especially as they often stated a preference for intimate sex with one individual – see section 5.6.

---

## 5.5 ENABLING SEXUAL ADVENTURE

Chemsex was universally described as more intense and adventurous than sex without drugs. A diverse range of sexual activity was common-place, which participants generally believed was far less likely to occur were the drugs not present. Almost every man talked of drugs helping them ‘lose their inhibitions’ relating to sex. Many were unable to articulate more than this common substance use discourse, but some, when prompted, described what ‘losing inhibitions’ really meant for them.

*“What I mean by, “Losing my inhibitions,” is you certainly don’t hold back. You don’t – I don’t have that moment of thinking, “Ooh, should I? Shouldn’t I?” You just do it. I don’t mean this in the literal sense, but you, sort of, go for the kill. Do you know what I mean? It’s like – you want something; you get it.”*

[Aged 28, diagnosed HIV positive]

Cognitive barriers or personal limits of sexual behaviour were often discarded while under the influence of

drugs, with men reporting willingness to engage in a much wider range of sexual activity, including: group sex; sex toys; S&M or bondage; graphic sex talk; role play; switching of usual insertive/receptive roles in anal intercourse (particularly when erectile dysfunction made insertive sex difficult); watersports; and dominant or submissive sex. Those who chose to inject drugs, especially crystal meth, often felt that this delivery mechanism facilitated even more extreme sex than when drugs were otherwise administered.

‘Chemsex was universally described as more intense and adventurous than sex without drugs.’

A large number of men reported a greater likelihood of engaging in fisting (ano-brachial intercourse) while under the influence of drugs, particularly crystal meth but also ketamine. Pre-existing limits of sexual expression were very person-specific but there was general agreement that drugs encouraged you to keep pushing boundaries to try new, and potentially more extreme, activities.

*“Crystal meth, when you inject it, it just feels very dirty. Just very sleazy. All your inhibitions just lower [...] You do stuff that you wouldn’t normally do, you would be into different fetishes that you probably wouldn’t usually be in to.”*

[Aged 24, diagnosed HIV positive]

Participants felt it was much more likely they would try to enact sexual fantasies while under the influence of drugs than if they were sober. Many such fantasies had been influenced by pornography. This was the case with both casual and regular partners with several of those in longer-term relationships describing how drugs could add excitement to a familiar, and perhaps staid, sexual setting.

Some men mentioned that drugs raised their pain threshold so that they were able to engage in physically rougher sex, including receptive intercourse from a large number of people in quick succession, or sex that was in other ways potentially painful.

*“The thing about crystal is it desensitises you so that you can do stuff you wouldn’t normally do. [...] Fisting. Double fisting. How much can I get up their arse? It’s so desensitised by the drug that [...] if you didn’t have any of those drugs, your body would be feeling stuff and you wouldn’t be able to do such extreme things”*

[Aged 48, diagnosed HIV positive]

This sense of sexual adventurism while on drugs was valued and facilitated sexual enjoyment. However, nearly all men described personal experiences where boundaries had perhaps been pushed too far or where

drugs were having a detrimental impact on longer-term sexual satisfaction. Some were concerned that once people (themselves included) began using drugs to facilitate more adventurous sex, there was a danger that this could continue unrestrained. A few men talked of “chasing the dragon” – always searching for the next high, the next level of sexual adventure or experimentation, never content with their immediate surroundings.

*“I think it might be partly because people are high and their attention span’s not really as good. It’s quite short and like they think, “I’m bored with that now, let’s try something else”. Constantly looking for more and extra stimulation.”*

[Aged 23, last tested HIV negative]

It was also the case that as men took more drugs in quick succession to enhance their sexual experience, they were more likely to overdose – leading to a complex situation for themselves and those around them (see section 7.1).

*“When people are on G it’s like their communication centre shuts down and it’s very much instinctual [...] But then also, because you’ve done too much it means you’re impotent – not with your penis, but in that you can’t actually do what you want to do, which is have sex. They’re so wasted they scrabble around for five minutes and then pass out.”*

[Aged 21, last tested HIV negative]

Engaging in more extreme sex also enhanced feelings of shame, particularly when men became involved in sex that was very submissive or, conversely, very dominating. Such shame was often assuaged with drugs in a complex spiral of chemsex reinforcement. While many men celebrated the sense of sexual adventure that drugs facilitated, a few had come to question where their fantasies were better left as fantasy. Some were very happy with their sex lives but others started to wonder whether drugs were enabling them to have the kind of sex they really wanted.

‘Some were very happy with their sex lives but others started to wonder whether drugs were enabling them to have the kind of sex they really wanted.’

## 5.6 SEXUAL (UN)HAPPINESS AND MAKING SEX BETTER

At the end of the interview, all men were asked whether they were happy with their sex lives and what, if anything, would help to make it better. Two-thirds said that they were unhappy, the reasons and potential remedies of which were discussed in detail.

By far the most commonly cited reason for unhappiness was the lack of a long-term, romantic partner. While enjoying the benefits of chemsex, many felt that drugs were not enabling them to have intimate and emotionally connected sex that was sustained over the longer-term.

*“It can get a bit lonely after a while when it’s just fuck and go, fuck and go, fuck and go. It’s not as if anyone stays the night anymore, that’s just the lay of the land these days.”*

[Aged 41, diagnosed HIV positive]

When asked what would make their sex lives better, most replied that they would like a boyfriend for intimate, mutually respectful and loving sex. Such findings resonate with recently published results of the EMIS survey, which showed that a sizeable majority of MSM in the UK held as their idea of the best sex life one which included a boyfriend or long-term partner with a sense of emotional or sexual connection (Bourne *et al*, 2013).

Those already in relationships (12 out of the 30 men interviewed) often said they would like better sex with the man they were with, including being more attentive to one another’s sexual needs and achieving a greater sense of intimacy and connection, which for some had diminished over time. Three of the twelve men in relationships had only recently met their partners and described how sex within their new relationship contrasted to sex beforehand, which often included high levels of drug use.

*“And what is it about your current situation that makes you happy?  
Having someone, and it not just being about sex you know, being able to talk to someone and not having to either it be about sex or drugs and all that.”*

[Aged 24, diagnosed HIV positive]

While a boyfriend was desired by a majority of those not already in relationships, most had struggled to find a

serious, romantic partner within a gay community where casual sexual encounters are perceived to be the norm, a situation facilitated by sexual networking apps and sex-on-premises venues.

*“Yeah. It’s a hell of a lot of difficulty finding a long-term partner in the gay world. Seriously, I’ve tried. I think all of these [\*app name] meets is – really, deep down, I’m just trying to find a partner to stay with, and to hold. I think I’m just picking the wrong app. I mean, it’s just not the place to do that, really. It’s just, you know, sex on tap. That’s what it is, really. That’s what it boils down to.”*

[Aged 31, last tested HIV negative]

Many felt that immediate sexual contact was expected by other men, which was not conducive to establishing or maintaining a longer-term romantic relationship. While drugs were not necessarily the root cause of gay social norms relating to casual sex, as described above, they were reported to facilitate sex with a higher number of men and could influence sexual intimacy.

Perhaps unsurprisingly given the data described in section 5.1, there were several men who were unhappy with their sex lives because of problems relating to self-esteem and sexual self-confidence, as well as suppressed libido. Their answer, therefore, to what might make sex better was to take more drugs.

*“I felt if I took more drugs I would have a higher confidence level and have more sex. Although I’ve been cutting down on drugs, I know that the sex is not as good and I’m not as confident to approach people and get sex, so I would like to take more drugs.”*

[Aged 40, last tested HIV negative]

Those who reported that they were happy with their sex lives presented themselves as in control of their drug use and confident in their sexual abilities and body image. They were typically longer-term drug users who were familiar with harm reduction information and had learned how to utilise drugs to enhance their sexual pleasure: perhaps enabling experimentation, partner turnover or sexual longevity, but within the confines of what they consider safe.



## 5.7 SUMMARY

- A large number of men had experienced, or were currently experiencing, problems relating to self-esteem or sexual self-confidence, which drugs helped to overcome (or at least mask).
- Drugs were reported as having very positive effects in terms of facilitating or enhancing sexual desire and sexual pleasure.
- Some men had become reliant on drugs and found it difficult or impossible to have sex without them.
- Participants often described how drugs could provide a more intense sexual experience and the ability to connect with another individual, although some lamented the fact that this effect was short-lived.
- Using drugs during sex meant that sexual sessions could be lengthened, enabling sex with more men and sex for longer with each man (although this was not always appreciated).
- Sexual activity could be more diverse or adventurous while under the influence of drugs, although there remained the possibility that personal boundaries could be pushed too far.
- The majority of men were not happy with their sex life and many desired a long-term partner for more intimate and emotionally connected sex.

# 6. THE ROLE OF DRUGS IN HIV/STI TRANSMISSION RISK BEHAVIOUR

As discussed in previous chapters, drugs played a very important role in the sexual and social lives of many of the men interviewed. They facilitated sexual pleasure and longevity of sexual contact, and could be used to overcome a variety of sexual confidence or anxiety related issues. However, section 1.2 briefly described the media and community concern that chemsex may be a driver of sexual risk behaviours and, at least in part, a contributor to HIV incidence among MSM in London. As such, a significant proportion of the interviews were devoted to considering sexual behaviours that might increase the likelihood of HIV or other STI transmission.

A crucial stage in understanding the specific role that drugs play is acknowledging and understanding men's broader perception of risk and their history of sexual risk-taking. All participants had experience of sex prior to their first use of chemsex related drugs and had means of managing the risk of HIV or STI transmission that were specific to their personal circumstances. This chapter describes the ways in which drugs impacted on sexual risk behaviour, including how their presence in sexual settings facilitated the rationalisation of risks that had already been taken. We begin by describing the perceptions and experiences of a group of men among whom unprotected anal intercourse (UAI) was both desired and normative, however drugs seemingly played only a limited role in their behaviour.

## 6.1 PRE-DETERMINED STI RISK BEHAVIOUR

Around a quarter of the men interviewed had made a conscious decision not to use condoms for most instances of anal intercourse. All of these men had diagnosed HIV and, for a variety of reasons, had made the decision to seek out sex only with men they knew or believed to also have HIV. The decision to seek out sex in this manner was, most often, carefully considered and rationalised, with little evidence that it had been influenced by the immediate effects of drugs.

Most often, the men who fell into this group felt that sex without condoms was more enjoyable. Physical sensation, stimulation and intimacy were all cited as reasons why they preferred unprotected anal intercourse, as was a preference for semen exchange between partners.

*“Instead of thinking, “Oh my god, I have to take medication” [when I received my HIV diagnosis], there was a sense of relief that I didn’t have to use condoms anymore. They’re physically irritating, even with lube and everything [...] So that’s why I tend to prefer to have sex with people that are HIV positive as well.”*

[Aged 37, diagnosed HIV positive]

There was a common perception among this group that condomless sex was the norm among gay men involved in the chemsex scene and that condomless sex was expected with other HIV positive men. This was, in part, driven by the visibility of men seeking out such sex in online environments. There was a certain popular website that many HIV positive participants used to meet other HIV positive men for sex without condoms.

It was also common for men within this group to identify other HIV positive men for sex without condoms via apps. Sometimes men would display their HIV status on their profile while at other times they might disclose their status in the course of discussion. While some men sought a categorical and explicit HIV status disclosure from their sexual partner prior to condom-less sex, others

relied on more implicit signs or signals. For example, men having unprotected anal intercourse (UAI) in settings where they perceived a higher proportion of men would be HIV positive, such as saunas or other sex-on-premises venues. Also commonplace were assumptions of HIV status made given the kind of sex that potential sexual partners desired, with interest in fisting often perceived as an implicit HIV status disclosure. Displaying similar behaviour themselves was, in turn, sometimes considered a disclosure of their own HIV status.

It is worth emphasising that all of the men interviewed took their HIV status seriously and were clear they did not wish to be the source of onward HIV transmission. While several men described hearing about ‘bug chasers’ – people purporting to be HIV negative but wanting to contract HIV – either from friends or in online environments, none had been party to such behaviour or witnessed it first-hand. Most were concerned by the thought they might infect others, and a few described their feelings of guilt that they may have infected others while previously undiagnosed.

*“I have infected a guy and, before I knew I was positive [...] I infected this guy and I will have to live with that for the rest of my life and it’s nothing to be proud of. In fact, just talking about it now, makes me feel sad, but he’s come to terms with it and as he’s said to me a while back when we made contact, he said to me, “well it’s not like you forced me to have bareback sex. I wanted bareback sex with you and I have to accept the consequences”, but that doesn’t make me feel any better. I still infected the guy.”*

[Aged 53, diagnosed HIV positive]

As has been widely documented in previous research (e.g. Bourne *et al*, 2009; Smit, 2012), fear of rejection was the primary reason why some men felt unable to explicitly disclose their HIV infection, or ask other men to clarify theirs. A fear, or prior experience, of rejection

‘Around a quarter of the men interviewed had made a conscious decision not to use condoms for most instances of unprotected anal intercourse.’

*“I am being absolutely open and honest and this may sound cold and calculated and maybe it’s against all of the health preventions and marketing materials and so on – but they [STIs other than HIV] are all manageable.”*

by sexual partners meant that many men with diagnosed HIV were hesitant to explicitly disclose, and this fear was the reason they relied on implicit cues within their environment. Some men were cognisant of the fact that their means of serosorting their sexual partners might not always be perfect, but were comforted by the knowledge that their undetectable viral load meant that they would be unlikely to transmit HIV anyway.

With regards to STIs other than HIV, men’s views and experiences were varied. A very small number stated they were unconcerned by any other STIs, now that they had diagnosed HIV. This was, they felt, the most serious of all sexual infections and their ability to manage and control HIV empowered them with the belief they could do the same with ‘lesser’ STIs.

*“I am being absolutely open and honest and this may sound cold and calculated and maybe it’s against all of the health preventions and marketing materials and so on – but they [STIs other than HIV] are all manageable. You take the pills, you have an injection. You’re going to be sick if it’s something like shigella or whatever it is, but you can come through it.”*

[Aged 33, diagnosed HIV positive]

This view was not common place, however, and most men both with diagnosed HIV and those believing themselves to be HIV negative were aware of other STIs and took at least some steps to avoid them. Most recognised that STIs were very likely to be transmitted within relatively small networks of HIV positive men choosing to have UAI with one another.

*“You don’t know about Hep C and other [STIs]. I mean I have had two or three STDs in the last 18 months and that is certainly up on the previous 18 months [...] When you arrange to meet somebody and they may have already been up and about for 24 hours, you are already inheriting whatever their last partner or partners that day may or may not have had.”*

[Aged 40, diagnosed HIV positive]

Several men had particular concerns relating to Hepatitis C and would directly question potential sexual partners to ascertain their infection status and the risk they may pose if they were to engage in unprotected sex. Others actively seeking to have UAI with other HIV positive men made an assessment of the likelihood of potential sexual partners carrying other STIs based on their profile, personality or sexual preferences. There was a common perception that men who engaged in fisting may be much more likely to have Hepatitis C, and therefore UAI should be avoided. Men who use crystal meth and those who inject drugs were also often perceived as more ‘risky’ and therefore more likely to carry STIs other than HIV. Some HIV positive men sought only to have insertive UAI, or insisted on partner withdrawal prior to ejaculation if engaging in receptive UAI, as a means of protecting themselves from other STIs.

*“If you think logically, yes I’ve had unprotected sex with other people but it tends to be the usual, “are you on meds? Are you undetectable? Do you have Hep C?” and I will avoid anyone that does fisting. As soon as anyone mentions the word fisting anyway, I block.”*

[Aged 41, diagnosed HIV positive]

Among this group of men we interviewed who frequently sought UAI, drug use played only a relatively minor role. Decisions relating to risk management were taken after consideration of their sexual preferences and in such a way as to limit the likelihood of onward HIV transmission. However, as described in chapter 5, chemsex facilitates longevity of sexual contact, meaning both the capacity to have sex with a higher number of men and the ability to have sexual contact with each man for longer. Both actions increase the likelihood of transmitting sexual infections.

‘There was a belief among many in this group that drugs, particularly crystal meth and GHB, made them so aroused that they could only focus on the possibility of sexual gratification.’

## 6.2 UNINTENDED SEXUAL RISK UNDER THE INFLUENCE OF DRUGS

In stark contrast to those men described above, a third of men described numerous instances of unintended sexual risk behaviour while under the influence of drugs. Most of these men generally sought to have protected sex (at least with sero-discordant or sero-unknown partners) but, for a variety of reasons, did not do so on all occasions. Drugs were frequently identified as a significant influence on their risk-taking behaviour, although the extent to which men were able to articulate how and why drugs shaped their behaviour varied considerably. Some men appeared to describe drugs as having myopic properties, in that they altered their ability to perceive the wider consequences of their actions.

*“I caught hepatitis B and it really taught me a lesson at the time not to do unsafe sex, but it just happens again. I guess also you reach a stage, maybe at night, where you care a little bit less [...] It’s probably the state of mind that the drugs put you in. You don’t think about any of that. The consequences.”*

[Aged 38, last tested HIV negative]

There was a belief among many in this group that drugs, particularly crystal meth and GHB, made them so aroused that they could only focus on the possibility of sexual gratification. Concerns relating to infection or transmission of HIV or other STIs became secondary in the midst of a chemsex session. Also commonplace were narratives of drug use and sexual risk-taking where men described feeling ‘carried away with the moment’, in that drug use in the sexual session had limited their capacity to attend to risk at the appropriate time. Such instances

often seemed to reflect some men’s wider problems in managing and negotiating condom use, which was exacerbated by the effects of the drugs in the sexual situation.

*“Last night it happened, I was horny with this guy, we were kind of grinding up against each other. He’s got his cock up against my ass, he’s kind of grinding and you’re thinking “oh, we should probably get a condom at some point”. “We should probably get a condom at some point, and we will, we’ll go and get a condom at some point before he actually penetrates” [...] And just gradually like that you end up fucking.”*

[Aged 32, last tested HIV negative]

The effect of drugs was also described as overpowering – removing the ability for rational thought or the maintenance of preferred, safer sex behaviour. There was evidence to suggest that this was more commonly the case for men using crystal meth, although not exclusively. Several men blamed drugs for their engagement in UAI with sero-discordant or sero-unknown partners.

*“So I met someone at a club called \*\*\* in the dark room and he was clearly on lots of drugs and he wanted me to go back with him. So I went there and he had a lot of mephedrone, which I took a lot of because it was there and I was offered and that was probably a gram, say, which to me is a lot. I had oral, anal sex so there was some unprotected sex there. And definitely as a result of taking drugs.”*

[Aged 40, last tested HIV negative]

‘The effect of drugs was also described as overpowering – removing the ability for rational thought or the maintenance of preferred, safer sex behaviour.’

A few men described a very clear transition in their sexual behaviour since beginning to engage in chemsex, from someone who was very risk aware and sexually cautious to someone who engaged in sex that carried a risk of HIV/STI transmission, which they later regretted. Sometimes such risky behaviour was confined to occasional 'slip-ups' or one-off risk incidents, whereas other men found themselves frequently engaging in risky sex and struggling to find a route out of it.

*“For me it [crystal meth] was very overpowering and it increased my sex drive. It made me actually want to explore myself sexually and have sex and with no regard or responsibility in terms of using condoms and who I was having sex with and how rough it was or how long it went on for and so I think more long-term it shifted my attitudes towards sex.”*

[Aged 24, last tested HIV negative]

Finally, there were men who described being so cognitively incapacitated by heavy drug use that they simply did not remember what they had done, including whether they had used condoms with unfamiliar sexual partners. Several others described feeling so overwhelmed by the effects of drugs that they had no conscious awareness of their actions.

*“I try to have protected sex but the thing is that when you're in a euphoric state, things happen. You might not be totally aware of what actually people are doing [to you] because you are that fucked.”*

[Aged 50, last tested HIV negative]

When UAI did occur, HIV negative men were sometimes able to rationalise their actions by acknowledging the modality of their intercourse (e.g. they told themselves they were insertive and thus less likely to catch HIV), or that they were not in receipt of ejaculate, or expressed

their belief that their positive sexual partner was likely to have an undetectable viral load. Others rationalised that despite being technically risky, their UAI with an unfamiliar party had felt 'safe' because he had no visible signs of being HIV positive, or lived in wealthy surroundings which, at the time, they did not associate with men who have HIV. Regardless of the tactics used to manage the risk of infection, across the whole sample around a third disclosed that they had been diagnosed with an STI in the previous year.

While four men explicitly mentioned seeking post-exposure prophylaxis (PEP) after instances of UAI with sero-discordant or sero-unknown partners, this usually only occurred when a personal 'red line' had been crossed – such as UAI in group settings or receptive UAI with someone they knew to be infected with HIV. Most experiences of UAI were not followed by this action, sometimes because men had not felt capable of accessing health services within the time period that PEP is recommended (in order to be effective, it is crucial that individuals access PEP within 72 hours of exposure to HIV).

*“I have thought actually, maybe I'll go to [\* sexual health clinic] today. Like I said, having blood drawn from me, I can pass out, it's quite a mission to have it done so I think actually, I'll just take my chances and not. I think if people come inside me, then I'll probably kind of be like “yes, I'll go and do this”. But there have been times when, I was at a party for so long if I picked anything up, PEP wouldn't work by the end.”*

[Aged 32, last tested HIV negative]

However, two of the professional clinic-based interviewees described how it was not uncommon for men to arrive at their clinic on a Monday morning, after a weekend of chemsex, seeking PEP.

*“For me it [crystal meth] was very overpowering and it increased my sex drive. It made me actually want to explore myself sexually and have sex and with no regard or responsibility in terms of using condoms and who I was having sex with and how rough it was or how long it went on for...”*

## 6.3 USING DRUGS TO RATIONALISE RISK TAKING

While the experiences of men described above largely relate to drugs having an unwanted influence over their sexual behaviour, a small number (less than a quarter) acknowledged that their relationship with drugs and sexual risk-taking behaviour was much more complex. They each expressed a willingness to engage in risk-taking behaviour as a means of living out sexual fantasies relating to dangerous or transgressive behaviour. Such behaviour and rationalisation links with how and why some men used drugs to expand their sexual repertoire and found confidence in them to live out sexual fantasies (described in 5.5).

*“Whilst on G, I allowed people to ejaculate inside me. So I was taking maybe more risks. But you know usually when I was negative, I never allowed that to happen because of the risks, my ability to control myself was inhibited, and I also, you know, allowed myself to get carried away in the moment and live out those fantasies that, you know, I had been fantasising about; dreaming about.”*

[Aged 33, diagnosed HIV positive]

Such experiences are different from those described in chapter 6.1, in which we described HIV positive men making decisions to engage in UAI with other HIV positive men in a considered manner (i.e. drugs did not have a significant role in their decision making). The men we describe in this section, however, *only* felt able to live out sexual risk fantasies when using drugs. All were conscious that they could blame their behaviour on drug taking, and that this would be a more socially acceptable explanation, but in fact acknowledged that drugs enabled them to do something they desired.

‘They each expressed a willingness to engage in risk-taking behaviour as a means of living out sexual fantasies relating to dangerous or transgressive behaviour.’

*“You actually knew what was going to happen. You did it on purpose. You had been saying to yourself all this time that the reason you have sex when you get high is because you only feel horny when you get high. Maybe that’s not true. Maybe you only allow yourself to have sex when you’re high or drunk because being high and being drunk is an excuse to not care anymore. It’s not necessarily that the drugs make you not care, it’s that you’re using them as an excuse so you can go off into this separate little bubble and say that’s not really me.”*

[Aged 32, last tested HIV negative]

One participant spoke of his emerging awareness of the role of pornography in his own sexual behaviour. He held a fascination with ‘bareback’ porn and acknowledged that this had developed from a fantasy into reality, facilitated by drugs which removed any prior inhibitions. While he perhaps was not conscious of the link between drugs, pornography and risky sex to begin with, reflection, both prior to, and during the interview had made this clear to him. Both this participant, and several others, emphasised that the transition from a fantasy of risky or socially transgressive behaviour into reality of sexual experience had been facilitated by the perceived prevalence of condomless sex within the networks of gay men who engage in chemsex. Some men felt that condomless sex had become so normalised among men who use drugs that it was difficult to insist on condoms being used, and also easier to rationalise not using them.

*“The fact that the majority of people who are in this scene are doing it bareback so if you want to be involved in that scene then that is the way you feel you have to go.”*

[Aged 40, diagnosed HIV positive]

Gaining an objective sense of how normalised condomless sex was within the networks of men who engage in chemsex was very difficult as participants differed in their views. As discussed in the previous section, a significant proportion generally sought to have protected sex with sero-discordant partners but felt that drugs influenced their behaviour and made sexual gratification more salient. The following section describes the perception and experiences of men who were adamant that personal rules relating to protected sex were always observed, even when drugs were used.

‘Men in this group described a greater sense of psychological well-being by using condoms, secure in the knowledge that they were unlikely to contract or transmit STIs.’

## 6.4 STRICT MAINTENANCE OF SAFER SEX BEHAVIOUR

It is important to acknowledge those men who had been able to negotiate safer sex all, or nearly all, of the time while under the influence of drugs. Nearly a quarter of participants had experience of chemsex within the previous year and had maintained strict personal rules about condom use with sero-discordant partners and partners of unknown HIV status. There were no obvious patterns in the drugs used by these men that distinguish them from men who did engage in UAI (deliberately or otherwise), although it is noteworthy that none were injecting drug users.

Men in this group described a greater sense of psychological well-being by using condoms, secure in the knowledge that they were unlikely to contract or transmit STIs. This was the case both for men with diagnosed HIV and those whose last HIV test was negative and was the case when using drugs during sex and not doing so.

*“How much do you think about HIV, and safer sex? Always. Always. I treat every person as if they are infected. It’s a morbid way to look at it, but it’s a way of keeping myself safe.”*

Is it the case you always use condoms?  
*Always. AIDS came around – just as I turned eighteen, the AIDS epidemic blossomed in the US, so my entire sexual history has been in the shadow of this monster, as it were. So I’ve never had unprotected sex.”*

[Aged 48, last tested HIV negative]

Such men were aware that others engaging in chemsex did not use condoms but were not willing to endorse this behaviour themselves. They took drugs during sex, were sexually adventurous and often had sex with a large number of partners, but were consistently safe when doing so. Several described their blunt reactions to suggestions by others that condoms not be used.

*“He also said, “Listen, you can’t fuck me with that dick, because it’s got a condom on it. I only do – I only have – I only want sex without a condom.” I said, “I’m always going to wear this condom, no matter what.” And I just thought, “This is the sort of environment that I’m in, where kids are playing with unprotected sex, and it’s not the sort of place that I want to be, to be honest,” and I walked out.”*

[Aged 31, last tested HIV negative]

The experiences and perceptions of these participants illustrate that drug use during sex does not automatically lead to HIV or other STI transmission risk behaviour. These latter men used drugs to enhance their sexual experience but always retained control of their actions. This was, as shown above, not the case for all those that we interviewed.

‘The experiences and perceptions of these participants illustrate that drug use during sex does not automatically lead to HIV or other STI transmission risk behaviour.’



## 6.5 SUMMARY

- A core group of HIV positive men had made pre-determined decisions to engage in UAI with men they believed to be sero-concordant. Drugs may have increased the volume of men they have sex with, and the duration of sexual acts, but did not appear to be the main driver condomless sex.
- Some men found it difficult to maintain control of their behaviour while under the influence of drugs and engaged in high HIV/STI transmission risk behaviour, which was regretted.
- There were men who had pre-existing problems negotiating safer sex, which were exacerbated by the presence of drugs, making it harder for them to negotiate sex they were comfortable with.
- A very small sub-sample of men sought out UAI and felt that this was facilitated by the drugs they took. Such behaviour was not always immediately recognisable, but usually related to playing out of sexual fantasies.
- Levels of understanding about HIV (including means of prevention) were ubiquitously high across the sample, but around a third of men who believed themselves to be HIV negative had engaged in UAI under the influence of drugs (either accidentally or with intention, sometimes with casual partners of unknown sero-status).
- Around a third of participants had contracted an STI within the previous year.
- STIs other than HIV were generally perceived to be not as serious (with the exception of Hepatitis C) and not all men with diagnosed HIV took steps to protect themselves from further sexual infections.
- A sizeable minority of those we interviewed frequently engaged in chemsex but felt in control of their actions, enjoyed their sex lives, and were, for the most part, engaging in sex with limited chance of HIV transmission.

# 7. NEGATIVE EXPERIENCES AND HARMS ASSOCIATED WITH CHEMSEX

Participants variously described how their drug/s of choice enhanced their enjoyment of sex, including its intensity and its duration. However, almost all participants also described negative experiences, arising from using drugs during sex, either for themselves or others.

This chapter outlines common and recurring harms perceived to arise from chemsex. These harms could be acute and immediate (e.g. overdosing), or they could be more long-term and pervasive. The majority of harms were not directly associated with perceived dependency or addiction, but instead related to a broader impact on physical, social or relational well-being.

‘the *vast majority* of participants reported some concern about the potential physical harms arising from chemsex and/or some actual physical impacts for them personally.’

## 7.1 HARMS RELATED TO PHYSICAL HEALTH

A small minority of participants reported few adverse physical effects of the drugs they took and favourably compared any minor ill effects they had experienced to the harmful effects of tobacco or alcohol use. Others felt they avoided the major physical health problems that could arise by avoiding crystal meth and/or injecting. However, the *vast majority* of participants reported some concern about the potential physical harms arising from chemsex and/or some actual physical impacts for them personally. Physical harms often included: immediate adverse effects, such as accidental overdose or exposure to STIs; medium term effects, such as fatigue and symptoms of withdrawal; and adverse effects that were longer-term, such as muscle wastage.

The process of taking drugs did, in some cases, cause injury. Many men mentioned damage to their noses (from snorting crystallised drugs), to their lungs and teeth (from snorting or smoking drugs), stomach upsets, reflux or abscesses. One man reported a painful fissure that had developed from inserting crystal meth into his anus.

A small number of men who had injected crystal meth described injection site injuries, such as damaged veins and muscle damage.

Few men reported acute negative effects with mephedrone, with exceptions relating to anxiety, irritability, disinhibition, paranoia, sleeplessness or a distinctive smell that was exuded from ones pores following its use. Occasionally mephedrone triggered bruxism (teeth grinding and jaw clenching) and associated teeth damage. Crystal meth use was also commonly associated with tooth loss and damage.

Withdrawal and hangover symptoms, coupled with fatigue or exhaustion, were often exacerbated by age, HIV infection or other illness. Disrupted sleep patterns were commonplace, particularly for men who used crystal meth. Some reported muscle wastage and weight loss that they attributed to chemsex, which was due to poor nutrition, loss of appetite and failure to maintain exercise routines.

### 7.1.1 Overdosing, and subsequent harms

Overdose was frequently reported, especially in relation to GHB/GBL, but also with regards to ketamine and crystal meth. Participants had also observed or experienced disorientation, dehydration, convulsions, fitting, vomiting, coma and death.

GHB/GBL overdose, described as going into a “G-hole” or “going under”, was considered particularly dangerous. Men explained how GHB/GBL has a relatively short effect, which meant the need for regular re-dosing. However, as mentioned in chapter 4, these doses need to be carefully timed and measured, which became more difficult to control as the effect of the drug accumulated over time. The drugs cognitive effects, including spatial and temporal disorientation, exacerbated the likelihood

of overdose. Even though some described considerable experience with safe, regulated dosing (such as setting alarms to avoid taking it too often, or keeping notes of dose and timing) overdose was very frequently reported and commonly regretted.

*“I need somebody else to tell me you are a bit fucked, go and have a lie down. Because it is one of those things where it is kind of slow acting and it will cumulatively dope up in your system. You don’t know that you have gone over the edge until you are falling off of the cliff face.”*

[Aged 50, last tested HIV negative]

The effects of overdosing were diverse. Participants described how being in a semi lucid state made them feel (and most likely appear) confused, distressed, agitated or aggressive. Some described an intense and overpowering desire for sex, which occasionally resulted in injury to themselves or others, unwanted sex with undesired partners or inappropriate sexual behaviour forced on others.

Short bouts of a loss of consciousness were very common but were perceived as relatively normal during sex with GHB/GBL. Some men described regaining consciousness only to find that they had lost considerable time, had lost control of their bowels or bladder, were in pain or vomiting or had been (or were in the process of being) penetrated without their consent. A few men reported being robbed in sex on premises venues while unconscious and suggested that others may have over dosed them deliberately for this purpose. Some expressed concern as to their own, or others, vulnerability in this state.

*“I would take G. I would always end up taking slightly too much and I end up having sex with someone I did not want to or there would be a couple of incidents where I would be on the verge of passing out and I would come round and realise I was having sex with someone without a condom [...] There have been a couple of times where I would freak out and be like, “shit what has happened, I need to sort this out”.”*

[Aged 24, last tested HIV negative]

Three men reported being the victim of non-consensual sex while under the influence of drugs, and several others reported that their friends or acquaintances had similar experiences. In all cases this occurred when men had taken an accidental overdose of one or more drugs and they felt that other men had taken advantage of them in their vulnerable state. Non-consensual sex was reported in a variety of settings, although one man recounted witnessing a particularly troubling incident at a private sex party.

*“I went to a party and there was only one person there who was passive; everyone else was active. And it very much – I felt uncomfortable because the person who was passive was rolling around in bed, moaning and sweating, “Oh I’ve done too much G”, and he was in a real state. I didn’t feel comfortable having sex with him but I didn’t feel it would be consensual but everyone else had no problem scrabbling around on top of him. And he kept saying no. And I was like saying, “It sounds like he’s in pain.” But I just couldn’t join in, it didn’t feel right.”*

[Aged 21, last tested HIV negative]

Those men who had personally been the victim of non-consensual sex were very hesitant to use the words ‘rape’ or ‘sexual assault’ because of what they, and others, felt was a particularly blurry line regarding consent in the context of chemsex. None had reported these as criminal incidents. Overdosing, particularly on GHB/GBL meant that men might drift in and out of consciousness or may cycle between pleasure and distress while having sex.

*“If someone had had too much and their inhibitions are reduced and none of it is really consensual, but then none of it is against anyone’s will. I think really it goes with the situation, it goes with the territory [...] Some people are giving consent but I mean is it really consent when someone is literally on the verge of passing out?”*

[Aged 24, last tested HIV negative]

Men talked about hospitalisation or death related to GHB/GBL commonly arising in saunas and clubs. While some had experienced this directly, others described how it had happened to friends, or had read about it in the news. There were five men who had been hospitalised due to severe overdose and had found this experience very distressing. They described hospital staff as being censorious, as well as their own sense of shame, embarrassment and horror.

‘Overdosing, particularly on GHB/GBL meant that men might drift in and out of consciousness or may cycle between pleasure and distress while having sex.’

‘Some participants described acute irritability, anxiety or aggression related to taking (or overdosing on) crystal meth...’

## 7.2 HARMS RELATED TO MENTAL HEALTH

Some participants described acute irritability, anxiety or aggression related to taking (or overdosing on) crystal meth, including several who required medical intervention for extreme paranoia and anxiety attacks following particularly intense chemsex sessions.

*“On this occasion I thought I was dying. I really, really believed I was dying and I so believed I would be dying within the next few minutes I’d made a decision in my head that I would just sit on the sofa and I’d just let myself go [...]The pains in my body I didn’t recognise. The anxiety, I just hadn’t physically felt a drug affect me in that way before, or panic me.”*

[Aged 48, diagnosed HIV positive]

Drug use was also blamed for longer-term harms to psychological well-being. Depression, anxiety, psychosis and regret were often experienced in the immediate period after a chemsex session, but in the longer-term some participants also reported memory loss and personality change.

A small minority of participants described drug dependency and two had received treatment for crystal meth addiction. At least two men had needed long term mental health treatment, which they ascribed to their use of crystal meth.

---

## 7.3 LOST TIME

When asked to consider the downsides of using drugs during sex, one of the most commonly cited issues was time. While many men valued the longevity, stamina and extended opportunities that drugs enabled in relation to sex, some saw it as time wasted and lamented the opportunity cost.

‘While it could be considered time well spent and enjoyable, men often felt they had lost control of their behaviour and found it difficult to regulate how long they spent looking for, or having, chemsex.’

Men talked about chemsex sessions lasting anywhere between 4 hours and 4 days and many expressed a sense of losing track of time. While it could be considered time well spent and enjoyable, men often felt they had lost control of their behaviour and found it difficult to regulate how long they spent looking for, or having, chemsex. Considerable time was also often wasted while recovering, which negatively affected productivity in relation to other valued activities.

*“I was doing drugs for three days on, then three days off, then three days on and three days off between about mid-July and mid-September. Not only do you lose the actual time but you lose time afterwards because you are recovering and not only recovering in the physical sense but, you are not operating properly. I mean the amount of things that I have been doing since I stopped has been insane. It is amazing what you can fit in the day, you know, when you don’t just get up at 2 in the afternoon.”*

[Aged 40, diagnosed HIV positive]

## 7.4 HARMS RELATED TO EMPLOYMENT AND FINANCE

Nearly half of men discussed the effect of their engagement in chemsex on their employment, ability to work effectively and career development. Most commonly they reported missing work because of “comedowns”, poor concentration and diminished cognitive ability, which all had a detrimental impact on their performance. A small number of men said they sometimes continued to use drugs such as mephedrone and ketamine prior to, or during, work in order to mitigate against tiredness or anxiety. A few participants reported loss of employment because of the impact of chemsex on their ability to function at work.

A number of participants talked about the considerable financial cost of drug use, in particular the high cost of crystal meth. The longevity of sexual arousal and common desire to access more sexual partners meant that further expenses were often incurred in relation to

taxis to and from saunas, private sex parties and dealers, sauna entrance fees, etc. A few men suggested they had spent enormous amounts of money over time.

*“I try to really space out the crystal so even if I am having a weekend of crystal, I’ll try not to have any for maybe two or three weeks because it’s so exhausting and expensive in many ways. Because if I’m slamming and that’s costing a hundred pounds, then all the other stuff that goes with it, the visits to numerous saunas, the taxi fares that I don’t care about, spending, the, I don’t know, all sorts of extra transportation costs and club ins and outs and you name it, and a couple of hundred pounds on ketamine, just because I’m at the dealer and I can’t stop myself buying more than I need, and giving it away often.”*

[Aged 48, diagnosed HIV positive]

---

## 7.5 SOCIAL AND RELATIONAL HARMS

Men frequently talked about how they behaved or related to other men when having chemsex. While many recalled looking after others who overdosed, sometimes irritation, sexual preoccupation, confusion, or disorientation resulted in men being ignored, stepped over or even assaulted when they had over-dosed. One man expressed his shock at behaviour that he considered to be uncaring when one man had passed out at a party but was left unattended while sex continued to occur all around him.

*“Seven hours after he passed out he came to, blood everywhere, vomiting, frothing at the mouth convulsing, called the ambulance, he was in hospital for two days. This is normal! Nobody’s sort of horrified, shocked and who knows what was happening to him when he was like that, people could stick it in and do what they like.”*

[Aged 40, last tested HIV negative]

Many participants were critical of the sexually focused and inebriated interaction with other men during chemsex, which stood in stark comparison to other social relationships, or their ideal romantic relationships. Drug use was sometimes seen as reducing consideration for others and promoting sexual selfishness.

*“I think it just makes you really selfish. I think that crystal makes you selfish, so if you’re a bottom you really want to get fucked. “My turn now, my turn in the sling, fist me”, whoever the guy is. I see this. Makes you selfish. It’s about me, it’s about me.”*

[Aged 48, diagnosed HIV positive]

Some men also described damage to relationships or hurt caused to partners, friends and families as a result of prioritising chemsex over social engagements.

*‘...sometimes irritation, sexual preoccupation, confusion, or disorientation resulted in men being ignored, stepped over or even assaulted when they had over-dosed.’*

‘Of these participants, many perceived an increasing normalisation of drug use; aided by sexual networking apps which facilitated the “excess” they saw around them.’

## 7.6 HARMS RELATED TO THE GAY COMMUNITY

A minority of participants expressed concern about the harms caused to the wider gay community by chemsex. These included a lack of care for one other and a perception of increased STI infection, and drug related injury and death. At a general level, chemsex was sometimes hypothesised as a way to treat, escape or alleviate symptoms of isolation, shame, or homophobia. Others saw it as a consequence of increasing freedom from discrimination for gay men, or as a rebellious reaction to normalisation of being gay. A few felt chemsex was perhaps a form of self-harm.

*“Why is it that we don’t seem to, as gay men, value our lives that much? Why are we upping the dose, why are*

*we just necking so many drugs, just escape to make us feel like porn stars who, ironically, can’t get hard-ons. There must be something in it. I could have died several times over the last year and yet I still continue. It’s not good.”*

[Aged 40, last tested HIV negative]

Some of the participants were also critical of a perception that chemsex was an integral part of a glamorous or desirable gay lifestyle. Of these participants, many perceived an increasing normalisation of drug use; aided by sexual networking apps which facilitated the “excess” they saw around them.

## 7.7 SUMMARY

- While drugs were reported to facilitate a high level of sexual pleasure, they were also associated with a range of physical, mental, social and relational harms for the majority of men we interviewed.
- Overdosing was an issue of significant concern for a large number of men, particularly in relation to GHB/GBL.
- Several men had been hospitalised as a result of overdosing, while others had experienced panic attacks, convulsions and loss of consciousness.
- Three men reported being the victim of sexual assault under the influence of drugs, and several others reported witnessing or hearing about the sexual assault of friends or acquaintances.
- Paranoia, anxiety or aggression were reported by some men who had been using relatively large quantities of drugs.
- Chemsex occupied a large amount of time for many men and a large number lamented the lost opportunities, both for social connection and/or for career progression, because of the time spent taking or recovering from them.
- Many participants expressed concern about the consequences of chemsex for the gay scene in London in general. Several referred to chemsex as a self-harming behaviour and were concerned that its visibility on sexual networking apps may further normalise it within the community.

# 8. MANAGING DRUG USE AND GETTING HELP

Men participating in the interviews were at a wide variety of stages of life and had vastly different drug taking histories coupled with a very broad range of concerns about drug use and sex. While the majority saw their drug use as relatively unproblematic, many had sought, or were seeking, greater control over their drug use (for sex). A minority told difficult stories of recovery and relapse and described the steps they had taken to try and limit their engagement in chemsex, or to overcome their dependence on drugs more broadly. This chapter outlines the ways men sought to manage their drug use (both within and outside of sexual settings), including how they tried to manage dosing and temptation. It also describes the experiences of men who had sought help in relation to their drug use, as well as the rationales of men who had not done and who generally felt help was unnecessary. The chapter closes by exploring the kind of service most men felt they would prefer to see for helping themselves, or others, in managing drug use during sex.



## 8.1 MAINTAINING CONTROL OVER DRUG USE

While this section is concerned with the ways in which all men managed chemsex in their everyday lives, it is briefly worth considering the accounts of the relatively few men who had previously lost control of their drug use and sexual behaviour and the steps they had taken to recover.

*“I got to the point where I said – I know I’ve got a problem [...] What happened with me is my dad – every month, my dad would have to come down [to London]. I got in such a state, he’d have to take me back home to [city name] for a week to recover.”*

[Aged 21, last tested HIV negative]

There were five men who clearly articulated a narrative of drug recovery. All were unique, although a pressing need to escape London gay life was present for each of them. Similarly, they all alluded to a loss of interest in sober sex, and a loss of interest in other aspects of everyday life.

*“There has been a big shift for me in the last six to nine months. I have actually been clean for nine months so that is off alcohol and drugs and I just came to a point in my life where I had reached absolute rock bottom and I spent five months in in-patient treatment [...] I had probably gone about three years in which time I had not had sober sex.”*

[Aged 24, last tested HIV negative]

Such stories of drug addiction were relatively rare, although many others feared it. Several other participants had realised that they needed to cut down or even stop their drug use for sex, either because it was having an impact on too many other aspects of their life, or they had experienced a drug-related event that shocked them, such as a hospitalisation or death among their social circle. The following participant had just been the victim of sexual assault in a chemsex party and this experience had called into question his entire sexual lifestyle.

*“I’m not going to say it’s easy, I’m probably still going to want to do them [chemsex parties] but I think I’ve reached the point where I can’t. There’s been times before I was okay for about a week or a week and a half, I know it’s not a long time, but it’s a long time for me and you kind of start thinking, okay, well, I can give it up and I don’t have to do them.”*

[Aged 29, last tested HIV negative]

Many other participants were seriously considering stopping or reducing their drug use, not because of a specific event, but simply because they felt they were approaching a boundary they did not want to cross – from drug use for recreation during sex towards drug use because it was required to have sex. Many had actively considered the need to bring their drug use under greater control.

*“So sex does not depend on having drugs available, so it is not [...] I think that when we were talking about boundaries and rules; that is sort of crossing from fun, enjoyable to something that is ruling your life. And again, it is crossing that boundary, it’s breaking one of those rules, then it’s time to say, no, this is a bad thing.”*

[Aged 46, last tested HIV negative]

Some guarded against possible drug dependence or addiction by avoiding specific drugs, such as crystal meth (and especially heroin). Even among crystal meth users, some said they would never inject because this was perceived to mark a passage into likely addiction. Others were willing to take crystal meth, but not to buy it, although this limiting strategy occurred with all the main drugs discussed.

The range of concern about drugs, and the strategies men put in place to manage the perceived risks of use

‘Many other participants were seriously considering stopping or reducing their drug use, not because of a specific event, but simply because they felt they were approaching a boundary they did not want to cross – from drug use for recreation during sex towards drug use because it was required to have sex.’

were hugely divergent. While many of the participants could articulate a line they did not wish to cross, where this lay varied enormously. Men's relationship to drugs for sex cannot be understood simply. Whichever drug men took, even if they felt themselves they took it too excess, they could still articulate another drug – or another means of taking it – that was more dangerous. For example, those men that that did not take crystal meth considered it a much more dangerous drug than any they were taking. Among crystal meth users, those that did not inject, held only this delivery mechanism as the problem behaviour. Even among those that injected, some described this act as relatively safe because, unlike others they heard of, they were not sharing needles (and not taking heroin).

‘While many of the participants could articulate a line they did not wish to cross, where this lay varied enormously. Men’s relationship to drugs for sex cannot be understood simply.’

---

## 8.2 MANAGING DOSING

Among the primary concerns about managing their drug use, the need to manage dosing, especially in respect of GHB/ GBL, was paramount. The use of stop-watches; (phone) alarms and even wall charts in sex parties was not uncommon. With GHB/GBL the concern not to overdose was keenly felt, because the majority of men had experienced partners or friends passing out, or had done so themselves (see 7.1.1).

In addition to a keen interest in the precise dose, and the time since the last dose, many men reported being very cautious of taking GHB/GBL-mixed drinks from others, especially if they were not trusted friends. Others were very cautious about only taking small quantities, especially from a new supply or supplier.

*“Again, another one of my rules is you can add but you can’t take away. I do smaller quantities at a bit, because you can add, but there is no way you can take away [...] especially the first couple of times I tried G, it would be in very small quantities. The first time I tried meth, it was in small quantities. I’d rather do little and build up rather than go in guns and suffer the consequences.”*

[Aged 46, last tested HIV negative]

Many men express difficulty in stopping taking drugs during chemsex sessions and some felt pressure to “keep up with” those men around them. Some men described looking after others who have taken too much GHB/GBL,

along with folk remedies such as keeping them awake, showering or encouraging them to ingest vinegar, sugar, orange juice or more drugs. Equally as common were stories of panicked men, in disoriented drugged states themselves, failing to recognise a worsening situation or medical emergency.

Commonly men described situations where overdoses potentially leading to death were dealt with poorly and in inconsistent ways, through others lack of insight, motivation, knowledge and the ability to deal effectively with the situation. Three men described accidents at sex parties where GHB/GBL had been mistakenly consumed in large doses (because the contents of a water bottle had been mistaken) leading to convulsions, coma and hospitalisation and, in one case, permanent injury.

‘Many men express difficulty in stopping taking drugs during chemsex sessions and some felt pressure to “keep up with” those men around them.’

## 8.3 MANAGING LIFE'S OTHER COMMITMENTS

While concern about (over)dosing was common among the majority of men, the act of drug-taking was not profoundly disturbing to many. Most felt they had control over their use of drugs for sex, both with regard to dependence or addiction and with regard to dosing and personal safety. Many participants were more concerned about the extent to which drug use negatively impacted upon other aspects of their lives. Managing drug use for sex so that it did not dominate whole long weekends or interfere with work commitments or relationships with partners (or sometimes friends and family) was a struggle for many men. Some explicitly recognised the costs of extended chemsex sessions and weighed this against the benefits.

*“I think I’m okay with the control bit. It’s because of the payback is the main thing, actually, that saves me. That I know that I cannot function at work or there will be a comedown for a very long time if I take too much drugs. So the control is the payback more than anything else. If there wasn’t any payback, I’d take loads.”*

[Aged 40, last tested HIV negative]

Some men managed to juggle their other life commitments, or at least put in place strategies to ensure that sufficient sleep was achieved so that they could function at work on a Monday morning. Indeed for some men, however many drugs they were taking, and however long their chemsex sessions were lasting, as long as they felt it was not interfering with their job or career or their primary relationship if they had one, then they were not too worried. Some managed their drug use by setting time limits on sauna visits. Other men limited the volume of drugs they used by carrying a very limited quantity when they planned a chemsex session. Others limited how often they took specific drugs, and allowed plenty of recovery time between chemsex sessions.

*“It’s very tempting and I don’t think it can really be controlled once you get going with it, I don’t think you can be sensible with it. I’ll take it, I’ll slam once, once a month and I’ll take anything else in between. Actually that probably wouldn’t be too unhealthy if you could just inject once and then give yourself a whole month to recover from that.”*

[Aged 48, diagnosed HIV positive]

---

## 8.4 MANAGING TEMPTATION

Many participants struggled to find and maintain a happy medium in which chemsex was part of their social and sexual life, but did not dominate it. Some had withdrawn from the gay commercial scene to avoid temptation. This was especially common among older men that felt the physical demands were becoming too difficult to bear.

*“I have to stop going on the gay scene properly because I will take drugs and I will just go from one club to another to another so I have to limit my clubbing now. I used to go clubbing like four days a week and have a chill-out for two days and I would have a nap in between. I couldn’t do it anymore, I am getting older and I am starting to feel older and I don’t want to ... End up in a box too early.”*

[Aged 36, diagnosed HIV positive]

The dominance of their social life by technology, people and places that had come to be integral elements of their chemsex was a real challenge to those men that

were trying to regain control of their drug use. There was a common perception that drug use was an inevitable consequence of engaging with the gay commercial scene (or at least some parts of it). Some men cited a range of clubs and saunas where they felt drug use was ubiquitous. However, when men sometimes found themselves wanting to avoid chemsex temptation the only option was to avoid those aspects of the gay scene. This was also true in relation to specific groups of friends

‘Many participants struggled to find and maintain a happy medium in which chemsex was part of their social and sexual life, but did not dominate it.’

‘There was a common perception that drug use was an inevitable consequence of engaging with the gay commercial scene (or at least some parts of it).’

who had to be avoided to escape the temptation of having chemsex, and was also true in relation to sexual networking apps. It was also one of the main reasons that men determined to quit their drug use felt they had to remove themselves from London and their established social activities, sexual and friendship networks.

*“I don’t want to be doing this. I like weekends. I like doing stuff. I like going out and meeting friends, like going to Greenwich Market. I like hiking in the Dales for god’s sake. I like being with friends and family. Those are all things that you lose out on doing if you’re fucking on G the whole weekend. But of course if you start doing it, you probably can’t stop.”*

[Aged 32, last tested HIV negative]

## 8.5 GETTING HELP WITH DRUG USE

Nearly half of the sample reported having never sought any professional help around drug use. Among those that had not sought any support, most re-iterated that their drug use was recreational and they had control over it. Some “justified” not seeking help by reminding the interviewer that their drug use did not interfere with their working life or their mental health.

*“Well I don’t think we’ve gone to that stage to be completely honest, because nothing’s the matter really. I’ve never lost a day of work as a reason so I haven’t had any issues or weird mood swings or nothing like that.”*

[Aged 38, last tested HIV negative]

Among the half of participants that *had* sought or gained some professional support about their drug use, what this constituted varied considerably. Some merely referred to websites or telephoned a helpline while, at the other extreme, a few had been admitted to in-patient care or rehabilitation. In some instances, concern about their drugs use had been the motivating factor for them seeking counselling, whereas in other cases discussion of drug use arose in discussion with counsellors as it linked to other personal issues (such as self-confidence, depression or concern about self-destructive behaviour). Participants frequently reported talking about drug use or chemsex with health advisors or counsellors at sexual

health clinics. Many considered the sexual health clinic the best place to discuss their drug use, without fear of judgement, and because of the intersection of drugs and sexual risks in their lives.

*“I think sexual health places seem more aware of gay issues from what I’ve seen and there seem to be more services available and stuff so I think it’s the best place for it whereas a GP might be seen more of a family place, so be a bit awkward sitting in the waiting room with the children and go and talk about like the extreme sex that you had the night before or something. I think that would be really awkward for people.”*

[Aged 23, last tested HIV negative]

A few participants went further and argued that “combined” drug and sexual health services would be ideal for helping them to address chemsex related problems. The aspiration was based on an earned and experienced trust that many men had developed with sexual health services – a relationship that simply does not exist for most gay men in relation to drugs services, or in relation to primary care.

*“There are a lot of services for sexual health and then there a couple of services offering for substance use and I definitely think they need a lot more combined*

services. There are a lot of psychological factors driving both and they are very much interlinked as it is [...] And I think the underlying issues are a lot more prominent than people believe or people acknowledge or people understand in terms of what is driving the drug use in the gay scene and sexual priorities and things.”

[Aged 24, last tested HIV negative]

While many men were comfortable with sexual health services and saw these as the ideal place to seek support about chemsex, some felt disappointed that there was not already more tailored drugs information available within them. Most participants had not sought out mainstream specialist drug services because they assumed that they would be ill-equipped to discuss chemsex and its associated costs and benefits. For some this was based on their concerns about disclosing their sexuality, or more commonly, the details of their sexual activity. For others, it was more about their perception that drug services all followed a 12-step model like *Alcoholics Anonymous*, and their discomfort with this.

“So I suppose if I was to go down that road of [of seeking help], I’d tap into the internet, find somewhere that I would need to go. I assume at the moment it would be a GUM clinic. Or my local doctor, I wouldn’t feel that comfortable going to my local doctors [...] I’d rather talk to someone that was more specialised in that area [...] and I’d want to speak to someone that understands gay men. Not necessarily has to be gay but has a better understanding as opposed to going to the equivalent of *Alcoholics Anonymous* or something.”

[Aged 46, last tested HIV negative]

Among the participants that had sought and received specialist sex and drugs support from services such as Antidote, the GMI Partnership or GMFA, or the more specialised gay men’s sexual health clinics such as Burrell Street or 56 Dean Street, there was widespread

satisfaction with the support received. This type of specialist agency, with skills and experience around gay men, sex and drugs were perceived to be pragmatic in their advice about managing drug use and the harms that might arise. The following participant really valued the harm reduction advice he received from one of the services named above.

“Yeah, I did go there once, just to try to get a better understanding of everything and how to manage it well and it actually did help. Well what he said was “it’s either you want to stop doing it or you want to learn how to manage it” He said that it’s okay if you don’t want to stop. It’s good that you learn how to manage it properly.”

[Aged 24, diagnosed HIV positive]

This need for practical harm reduction information was echoed by several participants. A few called for a helpline or posters and leaflets, while others merely bemoaned the need to learn about chemsex drugs informally, through trial and error, with limited options for formal advice and information (except through drug-user networks). Some also felt this lack of clear information was also a problem in general NHS services, like A&E, and even in drug services that were more used to opiate-based problems and their traditional solutions.

“Just one thing about the medical help, it’s a bit difficult when you go to an A&E and sometimes they’re not really aware of the side effect of drugs and the doctor was really honest with me when I went to see her. She wasn’t sure actually if the side effect was going to be a permanent thing and things like that. So it’s difficult, yeah, when problems happen. I know there’s some specific people you can go to. But when it’s the first time it can be a bit scary because I wouldn’t know exactly where to go to find help, to seek help.”

[Aged 31, last tested HIV negative]

‘Most participants had not sought out mainstream specialist drug services because they assumed that they would be ill-equipped to discuss chemsex and its associated costs and benefits.’

## 8.6 SUMMARY

- While around a third of men felt they had a problem with their use of drugs, the majority did not feel they needed professional help or support, nor that they needed to more carefully control their use.
- Five men had such a difficult experience of drug use (both within and outside of sexual settings) that they had to remove themselves, at least temporarily, from London and the gay scene.
- Many participants tried to manage their drug use by controlling their dosing and/or by limiting their engagement in chemsex, or their exposure to it.
- Where it was available, men valued clear, honest and non-judgemental information about how to use drugs and have chemsex safely.
- Men generally felt comfortable accessing drug information and harm reduction services in sexual health settings (both clinical and community based), or would prefer to do so in the future.

# 9. RECOMMENDATIONS

**We do not recommend a social marketing campaign on the dangers of chemsex (either LSL, London or national). Very few of the needs identified in this research are amenable to resolution via a social marketing approach. Instead there are a number of broad areas related to policy and practice that this research highlights.**

1. The men in this research repeatedly indicated a lack of harm reduction information relating to chemsex in gay sexual contexts. We recommend the production and dissemination of a range of resources that provide drug harm reduction information that addresses the following issues:
  - a. Safer drug use and harm recognition
  - b. Dealing with drug-related emergency situations
  - c. Consent, respect for others and reducing sexual exploitation
  - d. Transmission of STIs, including HIV and HCV
  - e. Sexual satisfaction and safety
  - f. HIV-related stigma and issues associated with HIV status disclosure
  - g. Community and social network opportunities that do not include drugs and sex.
2. We recommend ensuring access for men to gay-friendly drug and sexual health services that are competent to address the psychosocial aspects of their health and any harms arising from chemsex. These might include expert referral pathways between services for men who have complex physical, sexual and mental health needs.
3. We recommend co-ordinated work with managers of commercial sex-on-premises venues to facilitate development of clear harm reduction policies and procedures. This should include how to recognise and help those in distress as a result of drug overdose or sexual assault.
4. We recommend co-ordinated engagement (local, national and international) with commercial companies and gay media, including those who provide geo-spatial networking apps and websites, to explore opportunities for health promotion and harm reduction as part of a corporate responsibility to their users.

# 10. REFERENCES

- Bauermeister JA (2007) It's all about "connecting": reasons for drug use among Latino gay men living in the San Francisco Bay Area. *Journal of Ethnicity in Substance Abuse*, 6(1), 109-129.
- Bonell C, Hickson F, Weatherburn P and Reid D (2010) Methamphetamine use among gay men across the UK. *International Journal of Drug Policy*, 21(3), 244-246.
- Bourne A, Hammond G, Hickson F, Reid D, Schmidt A, Weatherburn P (2013) What constitutes the best sex life for gay and bisexual men? Implications for HIV prevention. *BMC Public Health*, 13, 1083.
- Bourne A (2012) Drug use among men who have sex with men: Implications for harm reduction. In C. Stoicescu (Ed.) *Global State of Harm Reduction 2012*. London, Harm Reduction International, pages 147-155.
- Braun V, Clarke V (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3: 77-101.
- Carey JW, Meijia R, Bingham T, Ciesielski C, Gelaude D, Herbst JH, et al (2009) Drug use, high-risk sex behaviors, and increased risk for recent HIV infection among men who have sex with men in Chicago and Los Angeles. *AIDS and Behavior*, 13(6), 1084-96.
- Channel 4 News (2014) Meth: causing a 'health nightmare' in London? Aired 30<sup>th</sup> January 2014.
- Cohen M, Chen YQ, McCauley M et al (2011) Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine*, 365: 493-505.
- Cooper C (2013) Party drugs linked to alarming rise in HIV amongst gay men. *The Independent*, 25<sup>th</sup> July 2013.
- Clark C (2013) A health needs assessment for men who have sex with men (MSM) in Lambeth. London: Lambeth Clinical Commissioning Group.
- Diguisto E, Rawstone P (2013) Is it really crystal clear that using methamphetamine (or other recreational drugs) causes people to engage in unsafe sex? *Sexual Health*, 10(2), 133-137.
- Fernandez MI, Bowen GS, Varga LM, Collazo JB, Hernandez N, Perrino T, Rehbein A (2005) High rates of club drug use and risky sexual practices among Hispanic men who have sex with men in Miami, Florida. *Substance Use & Misuse*, 40(9-10), 1347-62.
- Fisher DG, Reynolds GL, Ware MR, Napper LE (2011) Methamphetamine and Viagra use: relationship to sexual risk behaviors. *Archives of Sexual Behavior*, 40(2), 273-9.
- Forrest DW, Metsch LR, LaLota M, Cardenas G, Beck DW, Jeanty Y (2010) Crystal methamphetamine use and sexual risk behaviors among HIV-positive and HIV-negative men who have sex with men in South Florida. *Journal of Urban Health*, 87(3), 480-5.
- Foureur N, Fournier S, Jauffret-Roustide M, Labrouve V, Pascal X, Quatremère G, Rojas Castro D. (2013) *SLAM: Première enquête qualitative en France* [SLAM: First qualitative survey in France]. Paris: AIDES.
- Grov C, Parsons JT, Bimbi DS (2008) In the shadows of a prevention campaign: sexual risk behavior in the absence of crystal methamphetamine. *AIDS Education and Prevention*, 20(1), 42-55.
- Granich RM, Gilks CF, Dye C et al (2009) Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *Lancet*, 373: 48-57.
- Halkitis PN, Parsons JT (2002) Recreational drug use and HIV-risk sexual behaviour among men frequenting gay social venues. *Journal of Gay & Lesbian Social Services*, 14(4), 19-38.
- Health Protection Agency (2011) *HIV in the United Kingdom: 2011 report*. London: Health Protection Agency.
- Hopkins A (2011) Clubbed to death? *Time Out*, 22<sup>nd</sup> December 2011.
- Hurley M, Prestage G (2009) Intensive sex partying amongst gay men in Sydney. *Culture, Health & Sexuality*, 11(6), 597-610.
- Keogh P, Reid D, Bourne A, Weatherburn P, Hickson F, Jessup K, Hammond G (2009) *Wasted opportunities: problematic alcohol and drug use among gay men and bisexual men*. London: Sigma Research.
- Kirby T, Thornber-Dunwell M (2013) High-risk drug practices tighten grip on London gay scene [World news report]. *Lancet*, 381, 101-102.
- Klitzman RL, Greenberg JD, Pollack LM, Dolezal C (2002) MDMA ('ecstasy') use, and its association with high risk behaviors, mental health, and other factors among gay/bisexual men in New York City. *Drug and Alcohol Dependence*, 66(2), 115-25.
- Kurtz SP (2005) Post-circuit blues: motivations and consequences of crystal meth use among gay men in Miami. *AIDS and Behavior*, 9(1), 63-72.



- Marcus U, Hickson F, Weatherburn P, Schmidt AJ, The EMIS Network (2012). Prevalence of HIV among MSM in Europe: comparison of self-reported diagnoses from a large scale internet survey and existing national estimates. *BMC Public Health*, 12: 978.
- Mattison, A. M., Ross, M. W., Wolfson, T., Franklin D (2001). Circuit party attendance, club drug use and unsafe sex in gay men. *Journal of Substance Abuse*, 13: 119-126.
- Mayer KH, Colfax G, Guzman R (2006) Clubs drugs and HIV infection: a review. *Clinical Infectious Diseases*, 42(10), 1463-1469.
- Measham F, Wood D, Dargan P, Moore K (2011) The Rise in Legal Highs: Prevalence and patterns in the use of illegal drugs and first and second generation 'legal highs' in south London gay dance clubs. *Journal of Substance Use*, 16(4): 263-272.
- Morgan J (2012) Man dies at London gay sauna. *Gay Star News*, 28<sup>th</sup> October 2012.
- Morrison S (2014) Experts warn of rise in gay 'slamming'. *The Independent*, 19<sup>th</sup> January 2014.
- Nakamura N, Semple SJ, Strathdee SA, Patterson TL (2009) Methamphetamine initiation among HIV-positive gay and bisexual men. *AIDS Care*, 21(9), 1176-1184.
- Nutt DJ, King LA, Phillips LD (2010) Drug harms in the UK: a multicriteria decision analysis. *Lancet*, 376: 1558-1565.
- O'Byrne P, Holmes D (2011) Desire, drug use and unsafe sex: a qualitative examination of gay men who attend gay circuit parties. *Culture, Health & Sexuality*, 13(1), 1-13.
- Prestage G, Grierson J, Bradley J, Hurley M, Hudson J (2009) The role of drugs during group sex among gay men in Australia. *Sexual Health*, 6(4), 310-317.
- Rawstone P, Digiusto E, Worth H, Zablotska I (2007) Associations between crystal methamphetamine use and potentially unsafe sexual activity among gay men in Australia. *Archives of Sexual Behavior*, 36(5), 646-54.
- Reid-Smith T (2012) Man found dead at Chariots, London's biggest gay sauna. *Gay Star News*, 11<sup>th</sup> July 2012.
- Roberts S (2013) Department of Health 'concerned' by rising HIV stats for gay and bisexual men in London. *Pink News*, 25<sup>th</sup> July 2013.
- Rodger A et al (2014) HIV transmission risk through condomless sex if HIV+ partner on suppressive ART: PARTNER study. 21st Conference on Retroviruses and Opportunistic Infections, Boston, abstract 153LB.
- Ruf M, Delpech V, Osuagwu U, Brown AE, Robinson E, Chadborn T (2011) Men who have sex with men: estimating the size of at-risk populations in London primary care trusts. *International Journal of STD & AIDS*, 22(1), 25-29.
- Rusch M, Lampinen TM, Schilder A, Hogg RS (2004) Unprotected anal intercourse associated with recreational drug use among young men who have sex with men depends on partner type and intercourse role. *Sexually Transmitted Diseases*, 31(8), 492-8.
- Scrivner J, McGowan A, Stuart D (2013) *Recreational Drug Use amongst GUM Attendees – Implications for Service Delivery*. Poster presented at 19<sup>th</sup> Annual British HIV Association Conference, Manchester, 16<sup>th</sup>-19<sup>th</sup> April 2013.
- Semple SJ, Zian J, Strathdee SA, Patterson TL (2009) Sexual marathons and methamphetamine use among HIV-positive men who have sex with men. *Archives of Sexual Behavior*, 38(4), 583-90.
- Semple SJ, Patterson TL, Grant I (2002) Motivations associated with methamphetamine use among HIV+ men who have sex with men. *Journal of Substance Abuse Treatment*, 22, 149-156.
- Smit, PJ, Brady M, Carter M, Fernandes, Lamore L, Meulbroek M, et al (2012) HIV-related stigma within communities of gay men: a literature review. *AIDS Care*, 24, 405-412.
- Stuart D (2013) Sexualised drug use by MSM: background, current status and response. *HIV Nursing*, Spring, 6-10.
- The EMIS Network. EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey. Findings from 38 countries. Stockholm: European Centre for Disease Prevention and Control, 2013.
- UK Drug Policy Commission (2010) *Drugs and Diversity: Lesbian, gay, bisexual and transgender (LGBT) communities: Learning from the evidence*. London: UK Drug Policy Commission.
- Weatherburn P, Schmidt AJ, Hickson F, Reid D, Berg RC, Hospers HJ, Marcus U, The EMIS Network (2013). The European Men-who-have-sex-with-men Internet Survey (EMIS): design and methods. *Sexuality Research and Social Policy*, 10(4), 243-257.
- Weatherburn P, Stephens M, Reid D, Hickson F, Henderson L, Brown D (2000) *Vital statistics: findings from the National Gay Men's Sex Survey, 1999*. London: Sigma Research.
- Wood DM, Greene SL, Dargan PI (2013) Five-year trends in self-reported recreational drugs associated with presentation to a UK emergency department with suspected drug-related toxicity. *European Journal of Emergency Medicine*, 20(4), 263-267.