

**The substance use, sexual behaviour and health needs of
young tourists travelling to national and international
holiday destinations**

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Abstract

A growing literature base is identifying high levels of substance use and sexual risk taking among young tourists in holiday destinations. However, studies have predominantly focused on the behaviours of tourists visiting Mediterranean package holiday resorts or college students visiting spring break destinations. Limited research has focused on other *types of tourists* that exist in holiday destinations, or on *types of holiday destination*. Similarly, the health related behaviours of young tourists during their time in holiday locations have yet to be explored in any detail.

This PhD study seeks to address these gaps by firstly examining the risk and health related behaviours of young British casual workers in Ibiza, Spain, using both quantitative and ethnographic methods. Secondly, the research measures the changes in individual tourist's behaviours that take place pre and post-travel across a range of holiday destinations, using a novel three-stage longitudinal method. Thirdly, the research quantitatively measures the behaviours of tourists visiting the city break destination of Liverpool, UK.

The primary contribution of all three studies is towards an evidence base for tailored health literature and services that take into consideration the differing behaviours of tourist groups that exist within varied contexts. The study of casual workers in Ibiza provides a comprehensive understanding of how they exist in a complex environment where they must negotiate risk, and the importance of targeting this group with appropriate and relatable harm reduction messages. The longitudinal study of holidaymakers contributes towards an understanding of the full tourist pathway and how three-stage studies may be appropriate for future research. Finally, the study of tourists in Liverpool is the first of its kind in both offering a glimpse of risk behaviours in the UK, and in providing data on risky sexual behaviour and substance use in a UK city break holiday destination.

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List of Abbreviations

AOR- Adjusted odds ratio

Cis- Confidence Intevals

DJ- Disc Jockey

EHIC- European Health Insurance Card

GHB- Gamma- Hydroxybutyrate

GUM- Genitourinary medicine

HIV- Human immunodeficiency virus

LJMU- Liverpool John Moores University

LSD- Lysergic acid diethylamide

MDMA- 3,4-Methylenedioxymethamphetamine

NGO- Non-governmental organisation

NHS- National health service

PR- Promotional representative

SPSS- Statistical Software

STD- Sexually transmitted disease

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Rationale

A variety of studies to date have identified high levels of risk taking amongst tourists in global settings. Nightlife orientated holiday locations have come into focus due to the involvement of tourists in high risk activities such as excessive drinking, substance use and casual sex (e.g. Bellis et al., 2009; Hesse & Tutenges, 2008; Sonmez et al., 2006; Thurnell-Read, 2011). Young British tourists in particular have been found to take part in these high-risk behaviours and activities during their time in holiday destinations (Bellis et al., 2009; Briggs et al., 2011a; Downing et al., 2011; Hughes & Bellis, 2006). Nevertheless, this is still a relatively new area of public health research and there are many gaps in our knowledge of tourist behaviours in different contexts and between tourist types. Part of the reason is that existing studies are predominantly positivist in their approach, using only numeric forms of measurement, rather than subjective understandings (e.g. Bellis et al., 2003; Downing et al., 2010; Tutenges & Hesse, 2008). Similarly, there are speculative theories of risk behaviours of tourists in holiday destinations, yet few studies have evidenced such theory looking at social, cultural and environmental factors.

Studies have focused primarily on tourists as a generalisable population, yet a diverse range of traveller types visit holiday destinations such as backpackers, city break and package holiday tourists. Casual workers (or working holiday-makers) in particular are a relatively unstudied tourist population who spend extended periods of time in holiday destinations taking part in risky behaviours. Previous studies have identified this sub-group of working tourists as taking part in increased levels of substance use and risky sexual activities in comparison to regular tourists (Hughes & Bellis, 2004, 2006). Casual workers have also been noted as key facilitators encouraging tourists to take part in risky behaviours in nightlife settings (Briggs et al., 2011b; Tutenges, 2011). Nevertheless, research has yet to study this sub-population of travellers in depth and the little data that does exist on casual workers'

behaviour has mainly featured within holidaymaker based studies (e.g. Briggs et al., 2011b). For that reason, the following research will use a mixed method approach to understand the everyday behavioural norms and experiences of casual workers. This first study will seek to measure and describe the involvement of this group in high-risk activities and their subsequent health needs using both quantitative and qualitative methods, and will focus on a population working in a notoriously high-risk holiday resort. The findings of the study will contribute to filling a gap in research on casual workers as a specific risk population that are separate from short-term regular holidaymakers.

As well as traveller type, studies have yet to distinguish between different holiday types and destination choices and how this can affect risk behaviours that may be adopted. Tourists in holiday resorts may be exposed to high levels of risk behaviours over concentrated periods of time, which could potentially desensitise individuals to the involvement in deviant or even illegal activities (Briggs, 2012, 2013). Tourism studies have yet to measure changes in levels of involvement in risk behaviours both pre and post-travel. However, the use of such studies are important in potentially uncovering levels of recruitment to risk behaviours such as substance use, and the longer term effects that holiday behaviours can have on individuals. Consequently, the thesis has a second study that seeks to use a novel three-stage longitudinal method to measure tourists' behaviours before, during and after spending time in a holiday resort.

Previous studies have observed increased levels of involvement in risk behaviours in young British tourists visiting holiday destinations outside of the UK (e.g. Bellis et al., 2009; Briggs, 2012). Nevertheless, we know very little about changes in behaviour of young international tourists visiting the UK, and if the same increases in excessive behaviour are identified. Moreover, there are few studies that measure the behaviours of tourists on 'city break' holidays, with the majority focusing on beach holiday resorts outside of the UK (e.g. Briggs,

2013; Hesse et al., 2008; Sonmez et al., 2006). Observing such behaviour is important in order to identify how context may play a part in the way that health services could be potentially tailored in the future. Therefore, the final piece of research will seek to measure the risk behaviours of young international and national travellers visiting a 'city break' tourism destination in the UK, and their utilisation of health services during their stay.

In order to provide adequate recommendations for future health and harm reduction interventions and service provision in tourism destinations, it is vital that gaps in research are filled. Without such knowledge, we are unable to provide appropriate solutions that are tailored to individual populations of travellers across a range of destination types. The following research aims to contribute to our understanding of the behaviours and health needs of different risk populations in varied contexts. Mixed methods have been used to address the research questions and to explore the applicability of each method in varied settings, in order to evaluate the potential success of each method in future research.

Aims

- Explore the substance use and sexual risk behaviours of different types of young tourist populations in varying tourism destinations;
- Examine the utilisation of health services and health needs of tourist populations within differing tourist environments to identify gaps in service provision;
- Contribute to an evidence base for tailored health literature and services that are contextually appropriate.

Study level objectives

- (a) Review current literature on youth tourism and risk behaviours and identify gaps in research to be explored, focusing particularly on substance use, sexual health and utilisation of health services in nightlife orientated resorts;
- (b) Explore methodologies that have been previously used to measure risk behaviours in holiday destinations;
- (c) Identify a high risk population of young British tourists (casual workers) in a nightlife orientated resort and use mixed methods (quantitative and ethnographic) to measure and describe their levels of risk behaviour around substance use and sexual activity and their utilisation of existing health services;
- (d) Trial a method of identifying the impact of holiday risk taking behaviours on young people's longer terms risk taking by implementing a three-stage longitudinal quantitative study among

general holidaymakers to measure risk behaviours and utilisation of health services before, during and after the holiday;

- (e) Measure the risk taking behaviours of young tourists visiting the UK as a city break destination by implementing a short quantitative study among national and international visitors to Liverpool, examining levels of substance use, sexual behaviour and utilisation of existing health services;

Research questions

1. What risk and health seeking behaviours are exhibited by young casual workers in an international nightlife resort?
2. What are the everyday behavioural norms and experiences of casual workers that may affect involvement in risk behaviours and use of health services?
3. What changes in levels of individuals' risk and health seeking behaviours take place pre and post travel?
4. What risk and health seeking behaviours are exhibited by young travellers visiting a UK city break destination?

Thesis outline

Chapter 1: Introduction to concepts- The first chapter will introduce the topic of the thesis and the concepts that are going to be used throughout each study. This will include an explanation of the concept of youth tourism and its use in literature and policy; it will then describe the tourist-worker continuum on which many holidaymakers sit; and finally will discuss the concept of risk and its application to tourism and health, as well as theoretical understandings.

Chapter 2: Literature review- This is a review of the current literature on sexual behaviour and substance use in nightlife related holiday resorts, and the resulting health risks. The aim of the chapter is to provide a backdrop for the thesis and identify existing studies in this area that have led to the identification of gaps in research. The literature review begins by highlighting the theoretical understandings of young people's behaviours in tourist related risk environments; describing how individual perception and cultures of risk are formed within temporary settings. The review then focuses on the particular types of travellers that engage in risk behaviours and the destinations that they may visit. The review goes on to detail studies on substance use, including illicit drug use, polydrug use, legal highs and binge drinking; some of which are fairly new phenomena in health research. The health and behavioural effects of each are described using findings from previous studies into substance use and related risks.

In the review, studies on sexual behaviour abroad are described in relation to behavioural risk and factors that may influence involvement in casual sexual relationships in holiday environments. Similar to substance use, the health related consequences of risky sexual behaviour are detailed using findings from previous studies in this area. Substances are often used to facilitate or enhance sexual encounters, and can make people less informed about

their decisions; for that reason the review describes existing studies on this issue. Previous studies that have considered health initiatives and interventions in the context of tourism and risk are described, particularly in the case of sexual health and substance use.

Chapter 3: Research Methodology- Chapter 3 will describe the philosophical underpinnings of methodological approaches used in social research, including the paradigms of positivism and interpretivism. It will then describe the paradigm of mixed methods research and the strengths and weaknesses of this approach. The chapter will then go on to discuss methodological approaches that have been used in previous tourism and health research, and will discuss the application of methods to each study in this thesis. Finally, the chapter will describe the use of an ethnographic methodology and the strengths and challenges of such methods.

Chapter 4: The Ibiza casual worker study- This chapter begins by introducing the Ibiza casual worker study, firstly by describing Ibiza itself and its historical notoriety as a popular dance music and drug related holiday destination. Secondly, the introduction defines what is meant by casual workers and the role that they play within holiday destinations. Thirdly, it also looks at previous studies into this group in holiday resorts and their substance use and sexual behaviours.

The first half of chapter 2 describes the quantitative study, and firstly outlines the methods used to measure the behaviours of casual workers in Ibiza. This includes the reasons behind using a short questionnaire and the topics included in this survey. The recruitment process is also described along with the methods for analysing the data.

The findings from the quantitative survey are then presented. This includes the demographic findings such as age, gender, length of stay, type of work and reasons for visiting Ibiza. It also outlines the substance use behaviours of participants including levels of illicit drugs such

as ecstasy, cocaine and amphetamine, and levels of alcohol use and drunkenness. The findings describe the sexual activity that was measured, including the number of sexual partners and levels of unprotected or regrettable sex during their stay. Participants' substance use and related sexual behaviour is detailed in terms of relationships between such behaviours. Participants' utilisation of health services, exposure to health information and intentions for future health care are described.

The first half of the chapter ends with a discussion of the findings from the quantitative study including its limitations, and an overall conclusion.

The second half of chapter 2 describes the ethnographic study of casual workers in Ibiza, beginning with an introduction to the study outlining the reasoning behind the use of ethnographic methods to study this group, and how this method has previously been implemented in studies. Following this, a description of the ethnographic methods includes an overview of recruitment methods and the analysis of the findings. Then the findings of the ethnographic study in Ibiza are delivered, using themes that were generated throughout the analysis of the data. The social context of the Ibiza resort of San Antonio is detailed, allowing a backdrop to the further findings. The chapter then describes the findings in terms of the everyday behaviours of casual workers in this holiday environment, and the factors that have led them to take part in risk behaviours. The chapter also provides an overview of existing health services in Ibiza and barriers to access and utilisation.

The ethnographic study ends with a discussion of the findings and study limitations, and a short conclusion.

Chapter 2 concludes with a further discussion of the triangulated findings from the quantitative and ethnographic studies of casual workers in Ibiza combined. Findings are discussed in relation to each other, identifying any significant patterns that were highlighted

in both studies, allowing comparisons to be drawn. The discussion identifies important findings that should be taken into consideration for future research, and provides relevant recommendations. The chapter ends with conclusions on what has been found and how this contributes to the overarching aims of the thesis.

Chapter 5: The longitudinal holidaymakers study- The chapter introduces the study of holidaymakers pre, during and post-holiday. It outlines the reasons for using a longitudinal approach to the study, looking at previous examples of this method in literature. This study differs from the research on casual workers as it involves research around a general holidaymaker sample, visiting different locations around the world, rather than one homogenised population. The chapter then describes the longitudinal methods in further detail, including the recruitment methods and analysis of the findings.

The findings of this three-stage study are described taking into consideration the study drop-out rates and demographics, before exploring the data in terms of substance use, sexual health and the utilisation of health services by holidaymakers in differing locations. Again, the research differs from the Ibiza study in terms of the three-stage analysis and the measurement of change over three significant periods.

Finally, the chapter discusses the data in terms of significant findings identified. It also considers the use of longitudinal methods for tourism health research in the future and discusses the effectiveness of the sampling methods used. The chapter ends with a conclusion relating to the overarching aims of the thesis.

Chapter 6: The Liverpool tourists' study- The chapter begins with an introduction to the study, looking in particular at health concerns that are both inherent and prominent in Liverpool. This serves to provide a contextual background in terms of the justification for the location of the study, including information about Liverpool's background as a party capital,

and the health services currently available for tourists. This study looks primarily at tourists that are visiting Liverpool from overseas, but also tourists that are visiting from other cities in the UK. The purpose of the study is to understand the behaviours of tourists in the UK, including their sexual health and substance use, and their use of current health services available in the city.

The chapter then describes the quantitative method used in the study to measure tourists' substance use and sexual behaviours, and like the other studies also looks at the utilisation of health services during this holiday period.

The chapter concludes with a discussion of the findings, including an evaluation of the methods that were used to measure tourist behaviours, and recommendations for future research in this area. It ends with an overview of how this study relates to the aim of the thesis.

Chapter 7: Final discussion of thesis

The final chapter is a discussion of the thesis as a whole. It begins with a summary of the findings from each study and how they have met the aims and objectives of the thesis, and how each study may have been limited. Secondly, it follows with a discussion of the theoretical implications and healthcare and policy implications of the findings, and recommendations for future research. The thesis then ends with concluding remarks.

Introduction to the researcher

Before I begin describing the research that has taken place as part of this PhD thesis, it is important to both place myself within the research, and to give some background of how this particular topic became an interest to develop. This will also inform the methods that were chosen for the following research study. I am a young British female who has had first-hand experience of the risk environments that are being described in each study, and have a personal interest in nightlife arenas, having spent time in such environments at home and abroad. For that reason, I have entered this study in a position of primary knowledge and experience of the field that may affect the way that the research has been approached and my own behaviour and perceptions during the study period.

During my time spent at the University of Edinburgh during my undergraduate studies, I spent my summer holidays as a ‘working tourist’ in the resort of Kardamena, on the island of Kos, Greece from 2005 to 2007. From the outset, I identified myself as a ‘worker’ even before I arrived on the island due to my intentions to work immediately upon arrival at the resort. Some people arrive in holiday destinations as tourists and then decide to stay, however others arrive with the intention of working (even if they do not immediately find work). I had decided to arrive in Kos and find work in the first week. What gave me this sense of immediate identity as a ‘worker’ was being part of online ‘forums’ where those intending to work on the island would share stories, advertise jobs and chat about their plans for the summer. This only reinforced my need for an identity aside from a non-working tourist; I felt like we were a special group of individuals all seeking a life outside of the limits of a regular tourist, even if we hadn’t yet met.

I made a large amount of friends due to our shared goal of ‘making it’ as a worker. It felt like we were the lucky ones, being able to stay in a beautiful holiday environment for the whole

summer, when everyone would be getting on a plane home. It was thrilling. Even after arriving and spending my first two weeks on a tourist package holiday (and theoretically being a tourist) booked through a UK travel agent, I felt like this was part of ‘setting myself up’ to be worker. In having what I saw as hotel ‘base’, this allowed me to search for a job and private worker accommodation and gave me the security of knowing that I had a bed to sleep in and return flights should I decide against staying within that time. After all, I had never visited the resort, and had no idea what being a ‘worker’ entailed. Yet what drew me to be a worker was the idea of spending a summer in the sun with friends in an easy and fun job and making new friends from all across the UK (the majority of workers in the resort were young and British). That first summer I spent my days lounging by the pool and my evenings working in a Greek bar/nightclub until the early hours, and the weekends looking after a Greek child. I fell in love with the lifestyle, and told myself I would come back every year.

As an undergraduate Social Anthropology student, it was early 2007 when the time came to complete an ethnographic dissertation and to practice using fieldnotes, and for me it made perfect sense to study my fellow casual workers in Kardamena, especially as I had made so many contacts that could provide data. I was also very keen to go back to the island to see my friends and bask in the sunshine. Kardamena had a very busy bar street area and was surrounded by hotels that catered for young people wanting to drink excessively and party until the early hours. The majority of workers that I became friends with worked on the bar street area in bars and nightclubs, often as PR staff, bar staff or waiters/waitresses.

Nevertheless, as a young student I always felt more comfortable on the periphery of these nightlife areas of the resort, and had taken employment in a Greek family business on the outskirts of town. This allowed me to dip in and out of spending time with friends who preferred a party lifestyle of drinking until they passed out, sometimes on a non-stop basis. What interested me the most was the level of sexual activity that took place amongst casual

workers with whom I was acquainted, with casual one-off sexual encounters being commonplace amongst workers and tourists, fellow workers and local Greek residents.

Workers in the resort would chat openly by the pool about the amount of sexually transmitted diseases (STDs) they had, how many people they had had unprotected sex with, and how many more people they intended to sleep with before the end of the summer season. Females would tally up their scores of men that they had spent with and compete with each other, comparing notes and sharing their tales. However, at no point was there ever any mention of seeking medical attention or STD testing in Kos.

This intrigue led me to carry out my undergraduate ethnographic study of the sexual behaviour of young British casual workers in Kos entitled '*Why worry about it now? The normalisation of sexual health risk amongst young British casual workers in Kos, Greece*'.

At the end of my dissertation I decided never to go back to Kos, mainly due to 'growing up' and feeling a need to live a calmer lifestyle and focus on studies. My interest in this particular sub-group, casual workers, has continued and I still keep in touch with many of the workers that I met in Greece those summers, many of whom went on to work in other holiday destinations, such as San Antonio, Ibiza.

After my undergraduate studies, I relocated to the city of Liverpool for four years to take part in postgraduate studies at Liverpool John Moores University (LJMU). Due to my continued interest in the risk behaviours of young British casual workers, I had contacted Professor Mark Bellis and Dr Karen Hughes at the Centre for Public Health, LJMU, who specialised in the nightlife behaviours of young tourists in holiday destinations (and later became part of my PhD supervisory team). During this time, I worked part time in the city's nightlife industry, as bar staff in pubs and nightclubs, a host and a party planner, gaining first-hand knowledge and experience of young people's drinking behaviours. During my academic studies, I have always had an interest in dance music and have visited a number of nightlife holiday

destinations with nightclubs and bars that cater for this market, including Manchester, UK, Magaluf, Spain and Novi Sad, Serbia. However, the most attractive holiday destination to me has always been Ibiza, for its global DJs, beautiful beaches and parties that go on until dawn. Therefore in choosing a location to study the risk behaviours of young holidaymakers, this was a natural choice because of its reputation as a tourist party capital of the world.

As a PhD student, and a young female, it is important to understand my own connection to the research, including my personal interests that have inspired such a study. This has not only shaped the topic of the thesis, but also influenced the methods that have been chosen.

Chapter 1: Introduction to concepts

1.1. Introduction to concepts

In introducing the thesis, it is important to outline the concepts and terminology that will be used throughout. The thesis focuses specifically on the risk behaviours of young people who are holidaying or working in nightlife related holiday destinations. For that reason, it is essential to define why such specific groups and locations were chosen.

1.1.2. Young people and youth tourism

The thesis will focus specifically on young people travelling to holiday destinations around the world. In which case it is important to outline why such a group was chosen as the subject of the study. Previous studies of tourism have focused on risk behaviour in older populations, especially around sex tourism; for example, females aged 60 and over visiting the Caribbean for sex with locals (Anders et al., 1999; Taylor, 2000), or males visiting Asia for sex with sex workers (Davidson, 2003; Cohen, 1986). It has been said that in general older tourists tend to be more risk averse than younger tourists whilst on holiday, and tend to avoid any type risk tourism (Gibson & Yiannakis, 2002; Lepp & Gibson, 2003). On the other hand, youth have been found to actually seek holidays that involve partaking in risk behaviours, such as excessive drinking and casual sexual encounters (Sonmez et al., 2006).

The United Nations states that youth is best understood as:

‘a period of transition from the dependence of childhood to adulthood’s independence. That’s why, as a category, youth is more fluid than other fixed age-groups... ‘youth’ is often referred to a person between the ages of leaving compulsory education, and finding their first job’ (United Nations 2016: 1)

Therefore, they typically take youth as being within the age range of 15-24 years old.

However, they acknowledge that the definition of youth *‘perhaps changes with*

circumstances, especially with the changes in demographic, financial, economic and socio-cultural settings' (United Nations 2016: 2). Nevertheless, for this particular study the idea of youth is based upon the notion of 'youth tourism', although there is no one widely accepted definition of the concept (Carr, 1998), it is commonly associated with such groups as students and backpackers; those who may be more likely to travel for longer periods of time and seek enjoyable leisure exploits (Farahani & Sukmajati, 2011; Richards & Wilson, 2003). Youth tourism over the past few decades has been an area of mass growth with the advent of cheap flights to destinations around the world, and the emergence of youth package holidays specifically focused for young people seeking fun (Sellars, 1998). In 1991, the World Tourism Organisation (WTO) provided a working definition of the age range of 'youth tourism' as anyone aged between 15-29 years old, for use in statistical research (Farahani & Sukmajati, 2011). In 2015, the WTO estimated that 15-29 year olds accounted for 23% of all international travel across the world (UNWTO, 2016).

Although people of all age groups may travel to holiday destinations with specific nightlife arenas, youth in particular have been highlighted for their risk behaviours whilst in such settings. Schott (2004) commented that in the case of British youth in particular, youth tourism is associated heavily with 'hedonistic¹ behaviour', motivated by TV programmes such as 'Ibiza Uncovered' and 'Club Reps' that have been shown on UK TV since the 1990s. In these TV programmes, young people are seen to take part in behaviour such as drinking until they pass out, and having casual sex with people they have just met. Popular UK based youth holiday companies include 'Club 18-10' and '2wentys', and destinations may include places such as Falaraki, Rhodes or Ayia Napa, Cyprus (Knox, 2009). Such holidays are defined by 'sun, sex, sex and sangria' and include activities like lying by the pool, partying in nightclubs and drinking excessively (Batalla-Duran et al., 2003; Diken & Lausten, 2004;

¹ Hedonistic behaviour in this case is described as 'physical pleasures' (Schott, 2004)

Hobson et al., 1995; Rogstad, 2004). Youth holidays have attracted a great deal of media attention over the past few decades for the risk behaviours that individuals take part in whilst on youth package holidays; headlines such as *'Shock as girls have sex on floor in extreme Ayia Napa footage whilst on Club 18-30 style holiday'* (Drewett, 2016) and *'Binge drinking, rapes, squalid deaths: a former club 18-30 insider reveals the horrific truth about Brits abroad'* (Nicholas, 2008) are regular features of British tabloid newspapers over the summer months. As well as package holidays to European destinations, youth are commonly travelling to long haul destinations on backpacking trips or on a 'gap year' in between school and the beginning of University; and to city break destinations closer to home, both to be discussed in the literature review.

Within public health research that covers alcohol and drug use and sexual behaviour, previous studies looking at youth tourism and risk behaviours have looked at youth package holiday destinations such as Ibiza, Spain (Bellis et al., 2000; Briggs, 2013; Hughes & Bellis, 2004, 2006) and Sunny Beach, Bulgaria (Hesse & Tutenges, 2008; Tutenges, 2013). Public health related studies have also looked backpacker destinations, such as Australia, where young people will stay for lengthier periods of time (Hughes et al., 2009; McNulty et al., 2010). The age range for study participants for all studies was anything between 15-35 years old, which is a justifiable age range that would cover those that would be interested in such youth holidays. It was also chosen to capture those slightly outside of the typically youth holiday age of 18-30 years old, in order to widen the sample. Therefore, it can be seen that the age range of those taking part in youth tourism provided by the World Tourism Organisation (15-29) is not necessarily followed within these studies. This shows that the age range of participants within research studies can be dependent on such factors as the accessibility of participants, the type of participants or specifically tailored selection criteria.

Within this thesis, ideas of youth tourism will be shown further, but the ‘tourist’ will be described as someone who may work in a holiday destination, travel around a number of different countries, or take part in a short break for a few days; therefore, the concept of ‘tourist’ must be explored further.

1.1.3. The tourist worker continuum

The following studies within this thesis will be looking at a number of different tourist types; for example, those who are taking part in casual work in a holiday destination, and those who are on short stay city breaks. For that reason, it is essential to explore the concept of the *tourist* and its broad definitions to understand where the participants of the studies may sit on the tourist continuum.

The World Tourism Organisation (WTO) defines tourism as:

‘the activities of persons traveling to and staying in places outside their usual environment for not more than one consecutive year for leisure, business and other purposes not related to the exercise of an activity remunerated from within the place visited’ (UNWTO, 2016)

This definition may be accepted by many countries and organisations, but there is still no globally accepted definition of tourism as it can be a complex concept that differs amongst disciplines (Panosso-Netto, 2009). If we pay attention to second part of the WTO definition- *‘purposes not related to the exercise of an activity remunerated from within the place visited’* this suggests that a tourist is not someone who is paid or receives any payment for activities/ work completed whilst in the tourist destination that is visited. However, it is unclear what the boundaries are for a person who may be travelling for a holiday but may take part in casual paid work whilst in the destination, or those who travel to specifically take part in paid work but enjoy touristic exploits while they are there.

A trip where an individual may take part in paid work whilst in a holiday destination can be called a ‘working holiday’, defined in the Oxford English Dictionary as:

‘A holiday spent engaged in paid or volunteer work which is typically not one's usual occupation; (now) specifically a period spent abroad in which a person (especially a young person) undertakes such work’

(www.oxforddictionaries.com)

Similarly, the WTO definition of tourism claims that a tourist is someone travelling for ‘no more than one consecutive year’, therefore although there is no minimum time specified for a person to stay in a holiday destination to be classed as a tourist there is a maximum time given (UNWTO, 2016). This leads to the question of whether a person travelling to a holiday destination to both holiday and take part in paid work for more than one year may be classed as a ‘migrant worker’ or ‘expatriate’. The United Nations defines a migrant worker as:

‘a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national... where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor’

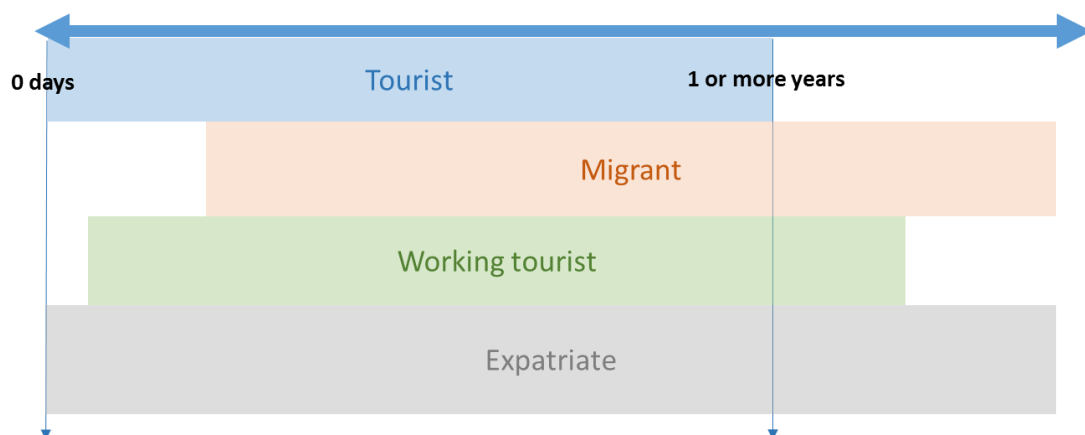
(www.unesco.org)

This definition is so broad that it would fit the description of someone who was travelling to a holiday destination to take part in casual work for more than one year. Similarly, the Oxford English Dictionary definition of an expatriate is ‘someone living outside of their native country’, which again could be applied to any working tourist if they are defined as ‘living’ in a holiday destination, which denotes more than one year (www.oxforddictionaries.com). However, previous studies have shown that people taking part in a ‘working holiday’ may commonly only stay in a holiday destination for a particular season, such as summer, before

returning home (Briggs, 2013; Hughes & Bellis, 2004, 2006; Tutenges, 2011). Similarly, in a study of Japanese people ‘migrating’ to Australia it was found that migrants were made up of three distinct groups; expatriates, those moving to study and working holiday-makers (WHMs), identifying each as a definite group with its own specific criteria but not based on how long they may be staying in the country (Kawashima, 2010).

When taking all of these definitions into consideration, it is clear that there is a broad continuum on which tourists can sit, demonstrated in the following diagram: -

Figure 1: Demonstration of the tourist worker continuum existing in literature based on definitions of tourists, working tourists, and migrants



Working definitions may have been provided by organisations such as the United Nations and the World Tourism Organisation, however within academia descriptions are not so concrete. Uriely & Reichel (2000) made a distinction between ‘travelling workers’ and ‘working tourists’, the latter described as ‘*tourists that engage in situations that combine work with tourism*’ (2000: 268). Therefore, the difference in the two groups can be found in

individual's motivations for leisure and recreation and responsibility/permanence of jobs, shown in the following diagram:-

TYPES OF TRAVELLER				
	WORKING TOURISTS		TRAVELLING WORKERS	
<i>Dimensions of comparison</i>	Working-holiday tourists	Non-institutionalised working tourists	Migrant tourism workers	Travelling professional workers
Work and touristic motivations	Work is grasped as a recreational activity that is part of the tourist experience.	Work in order to finance a prolonged travel.	Travel in order to 'make a living' and 'have fun' at the same time.	Travel in order to exercise work. Engage in tourist related activities as a by-product of the excursion.
Work characteristics	Unskilled but usually recreational manual labour. Extraordinary work. Unpaid work.	Unskilled and usually unpleasant manual labour. Occasional work. Low paid and non-prestigious.	Skilled or semi-skilled work in tourism economy. Repetitive seasonal employment. Unsecured and low paid employment.	Professional official role or business related work. Repetitive, career related work. Prestigious and well paid.
Demographic profile	Middle-class young adults	Middle-class young adults	Lower middle-class or working class single and unattached adults. Periodically unemployed in their home societies.	Middle or upper-class adults

Uriely & Reichel (2000:5)

Cohen (1973) had previously coined the term 'working holiday' as a form of tourism in which '*youth from one country travel into another to work for short periods, mostly during summer school vacations*' (1973:91). This definition, and that of Uriely's 'working-holiday tourists' (2000, 2001) may fit best with the type of tourists that will be studied in the following chapters of the thesis. However, as there are very few academic studies that have observed working tourists in nightlife orientated holiday destinations, an appropriate definition will not be given until further enquiry takes place to identify the characteristic of the participants.

What must be deciphered is the value of making a distinction between tourists who work in holiday destinations, and those who do not. In the case of this thesis, such distinctions may be valuable in providing public health interventions that are tailored to specific types of tourist groups. For example, there may be factors that differentiate short terms tourists from working holiday-makers in the delivery of contextually appropriate healthcare, or the way that they behave around alcohol and drug use. Yet on a wider level, it can be said that '*tourist*' can be an umbrella term that encapsulates all different types of individuals that may be travelling to a holiday destination, for whatever purpose.

Previous studies that have looked at the substance use and sexual behaviours of young tourists who are working whilst in a holiday destination have called the participants 'casual workers' (Briggs, 2011, 2013; Hughes & Bellis, 2004, 2006). Similarly, each of these studies have taken place in San Antonio, Ibiza (the location of the study in this thesis). For that reason, it was decided that the same terminology would be used to allow for consistency in studying this particular group in this location, and to allow for comparisons between studies in the future. In terms of how this relates to previous literature, it is unclear at this stage whether 'casual workers' in Ibiza would be classed as 'working holiday-makers' (Cohen, 1973; Uriely, 2001, Uriely & Reichel, 2001), 'travelling workers' (Uriely, 2001, Uriely & Reichel, 2000) or 'migrant workers' (www.unesco.org); therefore using the term 'casual worker' does not yet tie them to any specific existing definition. Subsequently, this will allow for an exploration of the population before a definition is applied, to be discussed later.

As this thesis sits within the discipline of Public Health, it is not only important to look at youth tourism but also specific areas of risk, such as excessive alcohol use, drug use and risky

sexual behaviour, which will be covered in the literature review. Yet, the very idea of ‘risk’ itself requires some explanation.

1.1.4. Risk

Firstly, the concept of ‘risk’ can be seen as a broad term, defined as *‘a situation involving exposure to danger’* (Oxford English Dictionary, 2016). Therefore, a ‘risky’ person can be seen as someone who may be vulnerable to actions that would lead to some kind of danger, directly or indirectly. Yet, the type of risk that is focused upon in this study is often voluntary risk and experimentation that requires a willingness of the participant to take part in an action knowing that there may be negative consequences, such as drinking excessively or taking illicit drugs. This can be viewed as ‘perceived risk’; which requires an individual perception of the level to which harm or danger may be an outcome of their actions, and whether the action is therefore ‘worth it’ (Slovic, 2000). Douglas and Wildavsky (1982) referred to the ‘knowledge theory’; which was an implicit notion that people perceive things to be dangerous because they know they are dangerous. Nonetheless, it can be unclear if people’s perceptions are fact or merely their own subjective understandings; in which case risk cannot be viewed objectively. Holdren (1983:36) expands on this by stating that *‘people worry most about the risks that seem most directly to threaten their wellbeing at that moment’*, meaning that perceived risk might be affected by how directly this might impact on a person’s life within a given time period. For example, an individual on holiday may decide to binge drink excessively in one evening, because they are caught up in the novelty and this is something they are being encouraged to do by their friends, therefore at that moment they may not consider how they may feel the next day. This means that risk taking can depend on the individual perception, and the context in which the risk activity takes place.

As outlined by Douglas (1992:11) '*the public definitely does not see risks in the same way as the experts*' and there are certainly not shared ideologies about risk within any domain. Both lay people and experts use the term 'risk' inconsistently, for example it may be a hazardous activity (e.g. skydiving), an adverse consequence (e.g. getting a speeding fine) or a probability (e.g. how many years of smoking would put me at risk of lung cancer?) (Slovic, 2000). In the context of risk behaviours in holiday destinations around drug and alcohol use and risky sexual encounters, it could be hypothesised that the latter is the most likely form of risk in this context. For example, a person may ask how many nights of drinking alcohol on holiday would lead to a problem with their liver.

Holiday destinations are commonly places where people go to escape responsibility and take part in behaviours that they would not normally do at home (Eiser & Ford, 1995). Therefore, perceptions of risk around drug use, alcohol use and casual sexual encounters may also be weighed-up depending on the perceived effect on or enhancement of their holiday experience. For example, excessive alcohol use may lead to a bad hangover (Pittler et al., 2005) but may also lead to increased confidence (Cooper et al., 1995); taking illicit substances may lead to an overdose (Degenhardt & Hall, 2012) but may also heighten feelings of love and closeness to others (Shewan et al., 2000); and unprotected sex may lead to acquiring a sexually transmitted disease (Carter et al., 1997), but it also may give a more pleasurable sexual experience (Brown et al., 2008; Randolph et al., 2007). It is therefore up to the individual to form their own subjective perceptions of the probability that a negative outcome may occur based on environmental and contextual factors around them.

Nevertheless, risk and knowledge are complex concepts that do not necessarily coincide, as some people may simply love taking part in risky activities, even with increased chances of danger. Tourists may perceive their holiday to be a period characterised by voluntary risk, adventure and experimentation. Some tourists can be recognised as having particular risk

taking personalities, such as seeking new thrills and sensations in different environments, such as experimenting with new substances (Kozak et al., 2007; Lepp & Gibson, 2008; Mura, 2010). In a study of tourists' sensation seeking practices, it was found that high sensation seekers were more likely to be characterised by novelty on holiday, whereas low sensation seekers seek familiarity (Lepp & Gibson, 2008). For example, backpacking may be more likely to appeal to people who are into experimentation and risk taking as it can be seen as travel into unknown areas (Hughes et al., 2009).

Within particular contexts, risk taking tourists can be described as both 'marginal' and 'deviant' because of their involvement in particular behaviours, such as drug use (Urielly & Belhassen, 2005) or sex tourism (Wickens, 1997). These terms may be used instead of 'criminal' to describe tourist's behaviours as such activities may be morally divisive and socially illegitimate, but not totally illegal (Urielly & Belhassen, 2005). A study of young holidaymakers in Ios, Greece, found risk behaviours were deliberately sought to increase levels of pleasure and enjoyment, for example having unprotected sex with a stranger and taking drugs (Mura, 2010). Similarly, in a study of young American students going on spring break, 19% of males intended to experiment with new drugs and over 42% of males expected to experiment sexually whilst on holiday (Sonmez et al., 2006). Therefore, again risk can be seen in terms of individual behaviour and attitudes towards risk, and how the consequences of risk are weighed up in each environment. Additionally, risk can be seen in terms of the status and achievement that may be attached to it and how risk takers may be perceived by others (Lepp & Gibson, 2008).

When looking at the context of some holiday destinations risk behaviours can often be expected, and some studies have shown that tourists have particular expectations and intentions for their time on holiday, such as engaging in casual sex (Ragsdale et al., 2006) or experimenting with new types of drugs (Sonmez et al., 2006). Individual perceptions and

expectations can also be built upon previous travel experiences (Kozak et al., 2007, Maticka-Tynedale & Herold, 1999; Mura, 2010). In a study of students on spring break, expectations to find an atmosphere characterised by risk, and prior experience of partaking in excessive drinking and casual sex were significant predictors of actual engagement in risk behaviour. This is reflected in the findings with over half of students (64% males, 51% females) reporting that they were drunk on their previous vacation, and over half (54% males, 51% females) of students expressing their intentions to get drunk again on the following spring break (Sonmez et al., 2006).

1.1.5. Risk and theory

The reasons why young people who engage in risk behaviours on holiday have been speculated by a number of researchers and theorists. Several commentators from sociological/ anthropological backgrounds have presented the idea of 'liminality' (Andrews & Roberts, 2012; Bell, 2008; Bloor et al., 1998; Graburn, 1989, 2004; Ryan, 1997; Shields, 1990; Thomas, 2005; Wickens & Sonmez, 2007). The term liminality typically describes a period of passage from one stage to another, such as a ritual, where a person no longer holds their previous status, but has not yet adopted a new status and the individual may be in a state of transition (Pearce, 2007). This can result in a state of disorder and malleability whereby the individual is establishing new norms and life is abnormal (Turner 1987; Van Gennep, 2011).

The concept of liminality originated from the work of Arnold Van Gennep in his influential work '*Rites of Passage*' (1906- published 1960) and was related to the symbolic and ritual processes whereby social transitions occurred, such as rites of passage. The liminal period described the 'in between' state that a person may be in when passing from one social stage to another, for example getting married, moving house or moving from one time period to another. Van Gennep distinguished between three different stages of the rites of passage;

separation, transition (the liminal phase), and reincorporation (post-liminal); and it was argued that these three stages were replicable across different cultures and societies (Thomassen, 2009).

Victor Turner later developed and built on the ideas of Van Gennep in arguing that some of the three stages of the rites of passage may be more pronounced than others. His work also drew wider attention to the concept of ‘liminality’ amongst sociological and anthropological academics (Andrews & Roberts, 2015). His work focused on the middle stage of transition and the condition of liminality that occurs, stating that ‘*in this gap between ordered worlds almost anything can happen*’ (Turner, 1974; 13). This condition, it was said, involved a period that was termed ‘betwixt and between’, whereby an individual may feel uncertain about what had occurred before and what was to come (Turner, 1967). Within this period, time is suspended and ‘anything can happen’. From this period of transition, a person can emerge with a new identity or social status. One of Turners’ arguments was that during the liminal phase there is an element of ‘play’ involved where people explore the familiar and unfamiliar and may be more open to experimentation, and people may reshape their new identity and status (Turner, 1982). He stated that:

*‘...liminal entities are neither here nor there: they are betwixt and between
the positions assigned and arrayed by law, custom, convention and
ceremonial’*

(Turner, 1969; 81)

This means that when an individual is in the liminal phase of a rite of passage they are not necessarily bound by law, morals or structure, as they explore their new identity and begin to form a new status. Therefore, people in this stage may not have any markers of their previous identity and they become indistinguishable from anyone else within that transition phase.

Turner also introduced the idea of ‘communitas’ (‘an area of common living’) whereby individuals who are involved in a shared ritual or transformative experience may engage in a sense of ‘*homogeneity and comradeship*’ in the activities and playfulness they may take part in (Turner 1969; 360).

‘Underscoring the sense of the liminal is the perception of unmediated encounters with other individuals also momentarily stripped of their social status’
(Shields, 1991:50)

This is something that may occur whilst an individual is in the transitional period of a rite of passage. Although individuals may exist in a liminal space ‘out of place and time’, they may still have the propensity for social bonds, familiarity and structural ties.

One of the most important developments of Turner’s work was the introduction of the concept ‘liminoid’ as opposed to ‘liminal’ (Turner, 1982). Whilst both of these terms refer to liminality as a concept and a ‘phase in between’, liminal describes something that is traditional or obligate, such as rituals and ceremonies, that may have religious or spiritual significance (Currie, 1997; Pearce, 2005). Whilst liminoid describes something non-traditional, optional and voluntary, like a passage to a leisure setting such as a holiday or creative activity, and focuses more on the actions of the participants in transition (Pearce, 2005; Thomassen, 2009; Turner, 1982, 1987). In this case, the liminoid sensations may be transformative but not necessarily transitional in the same way as a rite of passage (Andrews & Roberts, 2015).

Liminality as a concept has been used within tourism to describe the period of travel and the holiday destination as a liminal space/place. Graburn (1989) in his work ‘*Tourism as a Sacred Journey*’ followed the work of Van Gennep in describing the tourist experience as a rite of passage whereby the tourist follows the three stages of separation, transition and

reincorporation. The individual is separated from routine space and structures at home and entered a holiday space whereby behaviour may involve a level of play and experimentation, before they are then reincorporated back home in a renewed state (Graburn, 1989). Thus, individuals who are sharing the same tourist experience and taking part in the same activities in one place could be described as a 'communitas' (Turner, 1969). The holiday experience is commonly defined by behaviours outside of normal social codes, for example, more accelerated sexual relationships (Thomas, 2005) or increased levels of alcohol consumption (Bell, 2008). After this time, tourists may return to a 'post-liminoid' phase, which depicts a return to the ordinary everyday state, for example returning home after a holiday (Graburn, 1989). The type of behaviour that takes place in the transitional or transformative phase of the holiday can be described as 'liminoid' as it can be both ludic and playful, rather than a traditional rite of passage that can be more structured and formal (Andrews & Roberts, 2015; Bosley, 2009; Turner, 1982).

Liminal tourist spaces can be seen as places of exploration or relaxation; however, Shields (1991) identified that holiday experiences can also involve marginal behaviour such as illicit sexual encounters. Shields also stated that during liminal phases emotion and connection to structure can be suspended, therefore the person in the liminal stage becomes detached from emotional judgement from others and feel less of a need to uphold certain standards of moral behaviour. For that reason, there is a decreased fear of the perceived consequences of particular behaviours that may be deviant or out of the ordinary as it is felt that there is less risk to social status. Turner described this type of liminal situation as 'anti-structure'; whereby social boundaries are eliminated and everyone is socially equal (1969). During the liminal period of the holiday societal norms may be suspended and behaviours out of the ordinary may become more acceptable, particularly when away from structures of authority and responsibility at home. Such places where deviant behaviour is temporarily legitimised

have also been described as spaces where *'people can present their secret self relatively secure in the knowledge that this secret will remain invisible to wider society'* (Ravenscroft & Gilchrist, 2009:43). Shields argued that holidays represent a 'temporal shift' from the daily routines of employment from 'clock time to body time' (1991; 48). This means that tourists seek pleasure, consumption and freedom, rather than structure and routine, described as 'carnival' behaviour, an idea built on Bakhtin's theory of '*carnavalesque*' (Bakhtin, 1984). Bakhtin coined the term '*carnavalesque*' to describe a '*world inside out*' (1984:56), a period where individuals' worlds may be temporarily turned upside down whilst in a party holiday environment, hence they become involved in a kind of 'festive madness' whereby in that given space and time 'anything goes' (e.g. Briggs et al., 2011b; Shields, 1990). He describes this as:

'..a topsy turvy world during a temporal suspension of order where traditional hierarchies are set aside, social divisions are laughingly transgressed..'

(Bakhtin, 1984:158)

This has many parallels with the concept of liminality, and in particular Turner's focus on the more playful and spontaneous 'liminoid' phase.

More recently, scholars have applied Bakhtin's '*carnavalesque*' theory to describe youth holidays where individuals and groups may take part in hedonistic holiday experiences to create memorable experiences of that point in time. Travelling in groups and sharing memories enhances new and exciting experiences such as getting drunk, going to see DJs (disc jockey) at nightclubs and having casual meaningless sex (Brigg, Turner et al., 2012; Thurnell-Read, 2012; Tutenges, 2012). Part of these forms the concept of a narrative for the holiday experience, in the way that stories and legend are created from behaviour that is out of the ordinary whilst on holiday (Tutenges & Sandberg, 2013). Tourists may feel that they

can take part in risky behaviours as they are away from the constraints of home, and do not have to get up for work or school. Being away from home means that individuals are more likely to take part in risk behaviours if there is less chance of people finding out, or their reputation being tarnished (Briggs et al., 2011b; Thomas, 2005). This has been found to be particularly true in environments designed to promote uninhibited excessive behaviour where tourists are expected to 'let go'; for example hedonistic destinations like Ibiza (Briggs, 2012; Briggs et al., 2011b), and 'stag tourism' destinations such as Krakow (Thurnell-Read, 2012; 2012).

As well as the concept of liminality, tourism scholars have also described a term called 'situational disinhibition', the idea that individuals have a decreased sense of inhibition whilst in particular environments, or 'context specific disinhibition' (Apostolopoulos et al., 2002; Eiser & Ford, 1995; 326). This means that an individual may see themselves as a different kind of person whilst on holiday, as they may be less constrained by responsibilities and less worried about what their peers may think due to situational conditions (Maticka-Tynedale et al., 2003; Milhaussen, 2007). Again, this idea draws many similarities with the idea of limnality as individuals enter a holiday environment whereby normal social codes may be suspended or changing. Situational factors associated with being away from home can affect individuals' values and attitudes, and the social environment that the individual is in becomes the normal lived experience. For example, if an individual enters a holiday environment in which sexual risk taking is a common factor, this will eventually become a socially accepted part of the experience. This also draws comparisons with the idea of 'carnavalesque' (Bakhtin, 1984) whereby environments may be created on holiday whereby 'anything goes'. The holiday environment will simply provide access to new types of relationships, with different short-term goals, that are outside of social norms experienced at home (Eiser &

Ford, 1995). Nevertheless, it is unclear whether such theoretical understandings can be applied to all tourist types and experiences.

The introduction to the thesis has described the concepts of risk, young people and youth tourism that will be revisited throughout each study. It is important to outline understandings of each phenomenon in order to place the thesis within a particular context, and to provide a background to the terminology that will be referred to. The thesis will now outline the literature related to tourism and risk behaviour in more detail.

Chapter 2: Literature review

2.1. Literature review

The aims of the thesis are to:-

- Explore the substance use and sexual risk behaviours of different types of young tourist populations in varying tourism destinations;
- Examine the utilisation of health services and health needs of tourist populations within differing tourist environments to identify gaps in service provision;
- Contribute to an evidence base for tailored health literature and services that are contextually appropriate.

To be able to achieve these aims, firstly the existing literature around these issues must be identified. The purpose of the following review of literature is to identify gaps in knowledge, whereby further exploration is needed. In particular, the review aims to explore studies of different types of young tourist populations and their risk behaviours; identify different tourist contexts in which risk has been highlighted; and explore literature on health services and harm reduction in tourist destinations.

2.1.1. Introduction

Large numbers of young people travel abroad every year to holiday or work in tourist destinations. In 2014, for example, over 794,000 UK tourists visited the Spanish island of Ibiza alone, and these numbers are increasing (Balearic Institute d'Estadística, 2015). Many young travellers partake in risk behaviours while abroad that can be adopted or exacerbated in holiday destinations, and are often an effect of the immediate environment and levels of socialisation with other participants of risk. Risk behaviours such as casual sex, substance use and excessive drinking have been particularly identified in youth and nightlife focused holiday destinations. Examples of such are San Antonio, Ibiza (Bellis et al., 2008, 2009;

Briggs et al., 2011b; Briggs, 2012; Hughes & Bellis, 2004, 2006), Acapulco, Mexico (Monterrubbio et al., 2011), Sunny Beach, Bulgaria (Hesse et al., 2008, Hesse & Tutenges, 2009, 2011; Tutenges & Hesse, 2008, 2009; Tutenges, 2011), Panama Beach, Florida (Josiam et al., 1998) and the city break destination of Krakow, Poland (Thurnell-Read, 2011, 2012).

Studies have highlighted that excessive behaviour abroad is not without health risks. The effects of drug and alcohol use on holiday can include overdose, unintentional injury and violence (Bellis & Hale, 2000; Bellis & Hughes, 2004; Hughes et al., 2011); whilst risky sexual behaviour can cause the spread of sexually transmitted diseases, such as Gonorrhoea and Chlamydia, which can be brought back to home countries (Carter et al., 1997; Hawkes et al., 1997; Rogstad, 2004). However, holiday destinations can often be unequipped to deal with the large influx of tourists that may become a burden on their health resources (Bellis et al., 2003). Studies have yet to measure the actual utilisation of health services in nightlife holiday destinations, or investigate the types of services that are available and barriers to use. Without such information, adequate harm reduction measures cannot be tailored for tourist types and contexts, and recommendations cannot be properly informed.

Key risk groups that travel abroad and take part in risk behaviours have been identified in previous studies; such as short stay holidaymakers and spring breakers² (e.g. Bellis et al., 2009; Briggs et al., 2011b; Hesse et al., 2008; Monterrubio et al., 2015; Sonmez et al., 2006), longer term travellers/backpackers (Bellis et al., 2007; Hughes et al., 2009; Paz et al., 2004; Segev et al., 2005), those who go on ‘city breaks’ (Davison & Ryley, 2010; Dunne et al., 2011; Thurnell-Read, 2011, 2012) and those who take part in casual work in holiday resorts (Briggs, 2013; Hennink et al., 2000; Hughes & Bellis., 2004, 2006; Tutenges, 2011, 2012). In

² **Spring break** is a school or university holiday in Spring, whereby students congregate at holiday destinations. It is typically an American tradition.

particular, British tourists have been identified as a key substance using and sexually active population (Bellis et al., 2009).

The significance of existing theoretical ideas (described in the introduction to the thesis) is somewhat supported by the variety of research about the health risks that young people face in holiday destinations, especially involving drug use, binge drinking and sexual behaviour, from the USA (United States of America), UK and Denmark (Sonmez et al., 2006, 2013; Briggs, 2012; Briggs et al., 2011b; Hughes, Bellis et al., 2009; Hughes, Downing et al., 2009; Hesse et al., 2012; Tutenges, 2012). Nevertheless, throughout the literature there is a clear gap in research for further qualitative enquiry into risk behaviours in nightlife resorts, and ethnographic approaches may be the most appropriate way to understand cultures of substance use and sex. To fully comprehend the applicability of theoretical understandings of risk behaviour, the social and environmental context must be explored, as well as subjective individual understandings of behaviour. Very few studies have attempted to understand the context of risk, and studies that do exist only look at very small groups of youth package holiday tourists (e.g. Briggs, 2013, Tutenges, 2012); yet there are a variety of other traveller and context types.

This literature review will explore risk behaviour in those who visit particular holiday destinations. It will then identify research on risk behaviours in tourists and casual workers, focusing particularly on substance use and sexual behaviour. It will also discuss past research on the health needs of individuals in differing contexts.

2.1.2. Risk related travel settings

Travel has become increasingly accessible for young people with the advent of cheap package holidays and budget airlines (Bellis & Hale, 2000, Bellis & Hughes, 2004; Thomas,

2005) and a general increase in international airport destinations around the globe popularising the global backpacking market (Egan, 2009). Consequently young people have differing motivations for visiting destinations that can affect their behaviour and perceptions of risk, and it is important to look at these different contexts and traveller types.

Youth holidays

Every summer, millions of young people visit youth holiday resorts, usually for up to two weeks at a time, often travelling in groups. The motivation for youth holidays is typically ‘sun, sea and sex’, therefore tourists seek places to sunbathe and relax, alongside opportunities to party excessively (Thomas, 2005). Nightlife orientated youth resorts in particular are designed in such a way to provide a hedonistic playground for young people seeking uninhibited parting and excessive substance use (Duff, 2008; Sonmez et al., 2013). The structural, spacial and social networks that exist in youth holiday resorts can potentially create ‘risk enabling’ spaces such as specific streets full of bars and nightclubs, commonly known as ‘drinking strips’ (Briggs et al., 2011b; Sonmez et al., 2013). Scholars have described youth tourists as individuals that seek reckless abandon and hedonism in these types of environments, where their behaviour may be uninhibited over the short holiday period (Briggs et al., 2011b; Tutenges, 2011). This means that social relationships with other tourists and locals can often be accelerated and flirtations increased. Additionally, the time frame of such holidays means that normal social hours can be suspended and holidaymakers often party for longer lengths of time each day than they would usually at home (Thomas, 2005). A variety of youth holiday resorts have been previously explored, for example, Ibiza, a destination that hosts many British tourists (e.g. Bellis et al., 2004), Bulgaria, which is frequented by Danish tourists (eg. Hesse et al., 2008; Tutenges et al., 2008), and spring break destinations visited by American students, such as Mexico and Florida (e.g. Apostolopoulos et al., 2002; Monterrubio et al., 2015; Sonmez et al., 2006).

Youth holiday resorts are typically packed with bars, nightclubs and restaurants, with the main focus on providing a destination with a good nightlife (Thomas, 2005). It has been suggested that resorts may be designed to resemble the familiarity of nightlife venues in home countries such as the UK, which may further encourage behaviour such as excessive drinking (Andrews, 2005; Briggs et al., 2011b). Venues are typically concentrated in one area (e.g. 'the strip' or 'bar street'), providing an environment designed for maximum consumer spending and excessive behaviour. Nightlife environments usually include features such as loud music, cheap alcohol deals, and party activities such as karaoke and drinking games (Briggs et al., 2011b; Hesse et al., 2008; Tutenges et al., 2008; Tutenges, 2012).

Youth holidays are commonly sold by large holiday companies in the form of a 'package' that includes flights and hotel accommodation, as well as party activities and opportunities to socialise with other like-minded tourists (Hesse et al., 2008). The focus of such package holidays is typically on drunkenness, sex and other such hedonistic activities (Tutenges et al., 2008). This type of behaviour is often encouraged by holiday 'reps' or 'guides' who accompany holidaymakers throughout parts of their stay, such as organised bar crawls and day excursions. They are employed to provide entertainment and reinforce the party nature of the holiday (Hesse et al., 2008; Tutenges, 2012). Excessive behaviour is further encouraged by discounts on drinks, nightclub entrance fees and excursions for those who book a package holiday. Nevertheless, not all holiday reps exclusively work for 'youth package holiday' companies, and not all youth package holiday companies offer activities that revolve around drinking large amounts of alcohol, for example. Similarly, not all holiday reps are young, as many older adults (including expatriates) take part in holiday rep employment. However, for the purpose of the literature review and the focus of the thesis I have only referenced those who partake in nightlife arenas.

Long-term travellers and backpackers

Backpacker holidays usually extend over a longer period and involve travelling to a number of destinations. There is no 'one type' of backpacker experience; however studies have described this type of holiday as including periods of experimentation and experiences new cultures and new people. For example, previous studies have focused on different types of long term travellers, such as British backpackers (e.g. Bellis et al., 2007; Hughes et al., 2009), young Israeli travellers (e.g. Paz et al., 2004) and American students travelling to Europe and Asia (e.g. Hartjes et al., 2009) who have all take part in risk behaviours.

Travelling often takes place in periods between university and employment, often called a 'gap year' (Hughes et al., 2009). Therefore, for some backpackers importance is placed on taking part in activities that are free from restrictions and responsibilities at home. Israeli travellers, for example, often take time off after serving in the military, and therefore place emphasis on a life without boundaries whilst travelling (Paz et al., 2004). Travel can often be on a low budget as backpackers stretch their funds to enable them to travel for as long as possible; and backpackers sometimes take part in casual labour whilst travelling to help fund their trip (McNulty et al., 2010). Young people may also study whilst abroad to allow for international travel on a student visa (Hartjes et al., 2009). Australia in particular is a popular destination due to the fact that it is an English speaking country, with varied opportunities for employment that is and easy accessibility through short working visas allowing young people to stay for up to a year at a time (McNulty et al., 2010).

Backpackers can often be particularly motivated by meeting fellow backpackers whilst travelling, enabling them to share their experiences and gain information about potential destinations to visit (Murphy, 2000). Opportunities to socialise can also be increased by the use of the internet and travel forums that allow travellers to network and form social groups

(Hughes et al., 2009). Backpackers often stay in specific hostels that are designed to attract groups of travellers to socialise with each other, with entertainment aimed specifically at them; meaning that relationships are able to form quickly (McNulty et al., 2010). These forms of social interaction allow backpackers to form social groups and decide who they may want to travel with for periods of time; which is especially important for those travelling alone or in smaller groups (Murphy, 2000). Nevertheless, with the advent of social media it can be questioned that people may never be travelling alone, due to increased opportunities for communication. Although backpackers will not be intentionally studied in this thesis, it is important to identify that there are many different traveller types that have all been found to display similar risk behaviours.

'City break' tourists

City breaks typically involve travelling to a city centre destination for a short period of time; examples of popular destinations in Europe being Krakow, Poland (Thurnell-Read, 2012), Dublin, Ireland (Davison & Ryley, 2010; Dunne et al, 2011) and Paris, France (Dellaert et al., 1995). A commonly used definition of a city break is 'a short leisure trip to one city or town, with no overnight stay at any other destination during the trip' (Trew & Cockerell, 2002: 86), and can also be known as 'urban tourism' that is specific to only urban large cities (Law, 2002). City breaks can be characterised by the short stay nature of a trip, typically between one and three nights, which could be taken over a weekend (Dunne et al., 2007). This differentiates city breaks from other types of holidays which may involve travelling to a number of different cities in one trip, for example, backpacking tourism. Additionally, city breaks are to urban destinations with many activities and historical sightseeing opportunities, rather than beaches and swimming pools. Recent findings from a British 'Travel Trends Report' showed that city breaks have over taken beach holidays as the most popular type of holiday (2014 figures: ABTA, 2015). The advent of cheap air travel from UK airline carriers

such as EasyJet and Ryanair has greatly increased the popularity of city break tourism, and the ease at which people can visit city destinations, especially in Europe (Dunne et al., 2007; 2011; Graham & Shaw, 2008).

A study of city break tourists visiting Dublin found that the vast majority of visitors were from the UK, and were travelling as a couple with a sexual partner (Dunne et al., 2011). The study also found that participants were likely to travel anytime of the year and not within on particular season, therefore the draw was not necessarily sun and sand, unlike youth package holiday tourists. It was found that one of the main motivations for city break travel was the low cost and convenience of travelling somewhere not too far away for a few days, offering a small break from routines and responsibilities. There was also a desire by participants to take part in activities such as visiting tourist sights and ‘pubs and clubs’ (Dunne et al., 2011). Moreover, Dunne et al. (2011) found in this study and a previous study of Dublin city break tourism (Dunne et al., 2007) that a main city break motivation was to meet new people and socialise with friends, in a ‘fun’ and ‘lively’ destination.

Although city breaks are a popular exploit for young tourists and represented in urban tourism studies, they are not necessarily represented in health related literature. In the UK ‘stag and hen’ groups that travel to city break destinations have been labelled ‘party tourists’, characterised by binge drinking and recognised as an ever growing concern to British consulates due to the advent of cheap air travel to European city break destinations (Bell, 2008). However, there are few existing studies that have explored behaviours such as binge drinking, substance use or sexual behaviour in city break locations popular with such groups. Thurnell-Read (2011, 2012) has studied in detail the behaviours of tourists on city breaks in Krakow, Poland, yet this has only looked at ‘stag tourism’ behaviours of male groups, and not necessary ‘youth’ tourists. Moreover, although city breaks are commonplace for stag and hen groups, there are no studies that exist looking at other traveller health

behaviours within these destinations. Similarly, there are no existing quantitative studies that can provide data on city break tourists' risk behaviours. This is surprising due to such high levels of tourists partaking in this type of travel throughout the year. Interestingly, although the UK has many 'city break' destinations that attract visitors from all around the world, such as Glasgow and London, there are no studies that have measured the drug, alcohol and sexual behaviours of visitors during their stay. There only exists a UK based study of the behaviours of young British tourists in the beach orientated destination of Torquay (Carr, 2002a). For that reason, city breaks must be recognised for their potential to facilitate risk behaviours and studied in further detail.

Those who work in holiday resorts

Young people often take part in casual work in holiday resorts, typically over the summer season for around three to six months. This usually involves working in bars, nightclubs and restaurants, or for a holiday company. It is evident from time spent in a variety of Mediterranean holiday resorts and online worker's forums that young British casual workers are in existence in large volumes, taking part in seasonal work in bars and nightclubs. Yet there have been few studies on these groups and information from these are mainly quantitative (Hughes & Bellis, 2004, 2006). This means that there is a lack of understanding of casual worker characteristics and everyday behaviours while in holiday resorts, or their health seeking behaviours. Studies so far have only touched upon the role that they take in risk behaviours (Briggs et al., 2011a; Briggs et al., 2011b; Briggs, 2013).

Nonetheless, casual workers have regular contact with both tourists and local residents, and are often responsible for setting the social norms and expected behaviours in resorts (Hughes & Bellis, 2006). Working in bars and nightclubs over the season means that they are exposed to a hedonistic lifestyle for extended periods of time (Hughes & Bellis, 2004, 2006). Young

people are often employed by package holiday companies as ‘guides’ or ‘reps’. This commonly involves accompanying tourists on bar crawls and excursions to create a non-stop party atmosphere (Hesse et al., 2008; Tutenges, 2011; Tutenges et al., 2012). Casual workers have been found to both instigate and participate in risky sexual behaviour and substance use (Briggs et al., 2011b). A study in Ibiza found that workers were more likely to have had sex, had unprotected sex and sex with a greater number of partners than holidaymakers in the same resort (Hughes & Bellis, 2006). Similarly, they were more likely to use illegal drugs both in the UK and whilst in Ibiza, compared to non-working tourists. High levels of ecstasy use in particular were recorded within this specific population in Ibiza (Hughes & Bellis, 2004).

Holidaymakers take part in risk behaviours over short periods of time (e.g. 7-14 days), such as excessive alcohol use and unprotected sex. The consequences of some behaviour can easily be dealt with on return home to the UK through recovery or medical attention. Yet there is evidence to show that risk behaviours in nightlife holiday destinations could lead to serious injury or death (Briggs, 2013). However, little is known about the utilisation of health services by those who reside in resorts for longer periods of time, such as casual workers. Although a study has suggested that workers are ideally placed to deliver health messages to tourists (Hughes & Bellis, 2006), they could also be potentially contributing to increased levels of STD transmission and longer term health problems that may add to burdens on national health services. Therefore, further research is needed to measure both the utilisation of health services abroad by workers and the potential for targeted health initiatives for workers only. Further, the relationship between casual workers and tourists has yet to be studied in any detail to explore the power structures and networking that may exist.

Casual workers can be seen to set the social norms and boundaries for a holiday resort, and are more familiar with resorts infrastructure and culture. They can also be seen to have a

high status in resorts in the eyes of tourists (Hughes & Bellis, 2006). Therefore, it could be seen that such workers are critically placed to potentially shape the behaviours of tourists, therefore could be used to positively communicate harm reduction messages (Hughes & Bellis, 2004, 2006). Yet it has to be considered that workers may not be seen as role models that set positive norms and boundaries, and that tourists may be unlikely to adhere to messages delivered by workers. The relationship between casual workers and tourists may be subtle and complex, therefore we cannot assume that such harm reduction measure would work.

Ultimately, research is lacking on this ‘high risk’ subgroup of workers, and the effects that longer-term exposure to hedonistic environments and excessive behaviour may bring. In particular in terms of the associated health problems that come from long-term alcohol, drug use and risky sexual behaviour; and their health seeking behaviours.

Having identified different types of young travellers and theoretical reasoning behind risk behaviours, this review will now explore the types of hedonistic activities that have been identified in literature and that take place in youth focused destinations.

2.1.3. Illicit drug use in tourists

In the UK, illicit drug use is a particular concern with young people who are using substances recreationally on a weekly basis in many different nightlife settings (Moore et al., 2013; Parker et al., 2005; Wood et al., 2012). National statistics on drug use have shown that the frequency of drug use in 16-24 year olds is more than double that of adults, putting young people at the forefront of harm reduction strategies (Niblett, 2014). Estimates showed that higher levels of drug use are shown in those who visit bars and nightclubs more frequently, and in the past year alone just under a fifth (18.9%) of young people had used one or more

illicit drug (Niblett, 2014).

Illicit drug use has been found to carry a variety of health and social problems such as violence, overdose, dehydration and hyperthermia, and this is a prominent concern specifically for young people (Bellis et al., 2002). In England in 2010, young adults (aged 16-34) had the higher numbers of hospital admissions for health problems such as drug-poisoning and drug related mental health disorders than any other age group (Eastwood et al., 2011). Individual substances can be linked to different health and social effects; for example over use of amphetamines has been linked to paranoia and aggression (Sommers & Baskin, 2006; Wright & Klee, 2001) and continued cannabis use has been linked to respiratory problems, psychosis and depression (Arseneault et al., 2004;. Degenhardt et al., 2003). A cross sectional study of young people in nine European cities showed that the risk of violence almost doubled in males who used cocaine; with 37.3% of regular cocaine using male participants reporting that they had been involved in a physical fight (Schnitzer et al., 2010). Additionally, drug misuse can lead to instances of death, especially when using substances where the potency and content is unknown (Public Health England, 2016).

Drug use has been found to be common in nightlife venues such as pubs, bars and nightclubs (Measham, 2004, 2007; Measham et al., 2005). For example, individuals that attend dance music nightclubs have been found to binge on stimulant drugs such as ecstasy to increase their energy levels and keep them awake for longer periods of time, which caters to the energetic music that is played (Winstock et al., 2001; Bellis et al., 2000). However, drug use in nightlife environments can be particularly dangerous due to increased chances of dehydration as substances are mixed with alcohol in hot and overcrowded venues (Bellis et al., 2002). Many UK studies of substance use and nightclub attendance focus on gay men (e.g. Halkitis & Palmer, 2006; Measham et al., 2011). A recent study of gay nightclub attendees in the UK showed that 89% had tried an illegal drug in their lifetime, and half of

respondents stated that they had already, or were planning to consume an illegal drug on that night (Measham et al., 2011). Similarly studies have shown that gay men take higher quantities of GHB (Gamma- Hydroxybutyrate) to provide a feeling of relaxation and euphoria in more sexualised nightlife environments, such as circuit parties (Halkitis & Palmer, 2006).

A prominent concern is the increased use of illicit drugs by young travellers and holidaymakers, which has been measured in a number of studies (Bellis et al., 2003, 2007, 2009; Hughes et al., 2009; Paz et al., 2004; Sonmez et al., 2006). However, there have yet to be any studies that look at how drug use occurs and why it may be popular in holiday destinations. A study of UK holidaymakers in Ibiza found a substantial increase in the frequency of drug use on holiday, with 36.9% of ecstasy users taking ecstasy five or more nights in Ibiza, compared with only 6.7% using five or more nights previously in the UK (Bellis et al., 2003). Similarly, in a study of young British backpackers, it was found that over a quarter of those who used cannabis in both the UK and Australia, used in Australia at a considerably higher frequency (Bellis et al., 2007). Although there are existing studies of drug use in holidaymakers in different settings, there are still no studies that have measured the drug use of those holidaying in the UK.

Studies have shown that young people are often recruited to and experiment with new types of drugs during their stay abroad (Bellis et al., 2003, 2007, 2009; Segev et al., 2005). This has been found to be particularly true in nightlife-orientated destinations with generally high levels of drug use, such as Ibiza (Bellis et al., 2009). A study of young international holidaymakers showed that 7.2 % of British tourists and 8.6% of Spanish tourists were recruited to ecstasy in Ibiza; similarly, 5.1% of British respondents had relapsed into ecstasy use after not using in the previous 12 months before their holiday (Bellis et al., 2009). Young British backpackers have also been found to use new substances with findings showing that

3.0% of travellers used cannabis and 2.7% used ecstasy for the first time whilst in Australia (Bellis et al., 2007). Concentrated periods of drug use can be problematic as it is not known if this could increase the probability of continued drug use on return home from the destination, a major omission in substance use literature. Consequently, this could increase the risk of individuals gaining long term substance use habits (Bellis et al., 2002).

The types of drugs used by holidaymakers can be related to the particular holiday destination, and the type of user. It has however been highlighted that the type of substance used by tourists can depend entirely on availability and price (Bellis & Hale, 2000; Paz et al., 2004). In dance music related nightlife destinations, such as Ibiza, ecstasy and cocaine use by British holidaymakers has been found to be higher than at home in the UK, with users found to binge over short periods of time while they are abroad (Bellis et al., 2003; Hughes & Bellis, 2004, Hughes et al., 2009). In a study of young British tourists in Ibiza, 44.2% used ecstasy and 34.2% used cocaine during their holiday (Hughes et al., 2009). This may be because people regularly visit all night dance music events and consume drugs that are associated with dancing and high-energy movement (Bellis et al., 2003, 2009; Hughes & Bellis., 2004, 2006). Although these reasons are only speculative at this stage in literature.

Longer-term travellers and backpackers have been found to consume higher levels of relaxant drugs such as cannabis (Bellis et al., 2007; Paz et al., 2004; Segev et al., 2005). It has been suggested that backpackers may be less likely to consume tablets like ecstasy and powders like cocaine due to their unknown content (Bellis et al., 2007). However substances like cannabis are seen as a safer option as it keeps the traveller more in control, is a 'lighter' type of drug and is seen to have less negative health consequences to the individual (Bellis et al., 2007; Hellum, 2005; Paz et al., 2004). Cannabis may also be seen as a more practical drug to use whilst travelling as it can be used as a tool for socialising as it is passed around (Bellis et al., 2007). Such examples show that recreational drug use and choice of drug type can have

differing meanings and purpose for holidaymakers in environments that may differ from drug use at home. For that reason, the social purpose of drug use requires further investigation, particularly to enable health messages that are contextually appropriate.

Use of substances on holiday has been found to have varying social effects on individuals, such as enabling the loss of inhibitions and increasing levels of socialisation with other tourists (e.g. Briggs et al., 2011b). However, substantial negative effects have been measured, such as increased amounts of violence and injury (Calafat et al., 2013; Hughes et al., 2009, 2011; Hughes, Bellis et al., 2008). In a study of young people visiting Mediterranean destinations, illicit drug use both at home and on holiday was significantly associated with violence, particularly in British travellers. Of drug users that got involved in a fight, 16.2% were under the influence of illicit drugs at the time (Hughes et al., 2011). A study of young British, Spanish and German tourists similarly found that the odds of fighting almost trebled in cocaine users and doubled in cannabis users (Hughes, Bellis et al., 2008). Illicit drug use on holiday has also been found to contribute to higher levels of risky sexual behaviour, to be discussed further in the review (Bellis & Hughes, 2004; Bellis et al., 2008; Hughes et al., 2009; Thompson et al., 2005).

Of concern, research has indicated that tourists may perceive substance use as less hazardous abroad than at home, and risks may be quickly forgotten in new environments away from constraints and responsibilities at home (Uriely et al., 2006). Nevertheless, levels of risk can be increased by consuming substances in hot climates, leading to increased risk of dehydration (Bellis et al., 2002). If a health problem should occur, substance users may be in unfamiliar foreign settings whereby the individual may be isolated from necessary support services and distanced from influential networks such as family (Bellis et al., 2009).

Additionally, the purity and legality of substances abroad may differ, and ingredients may not always be as expected (Lora-Tamayo et al., 2004); with drugs containing unfamiliar

compounds leading to unexpected effects on the individual (Bellis & Hale, 2000; Hughes et al., 2011).

2.1.4. Polydrug use

A characteristic of substance use is polydrug use; using two or more illicit substances at the same time to balance or maximise the effects of other drugs or alcohol. Estimates of polydrug use in England in 2011/2, found that around 7% of 16-59 year olds questioned reported polydrug use. With almost all of the cases (95%) reporting the mix of substances: cannabis, ecstasy, amphetamine and cocaine (Home Office 2012). Although there are no more recent reports, European figures have also previously reflected increasing amounts of polydrug use in the UK; with findings showing that over 50% of cocaine users are simultaneously using ecstasy, as well as consuming high levels of alcohol (EMCDDA, 2009).

Research has found that polydrug use can increase health risks as substances are mixed together with alcohol potentially forming dangerous and toxic chemicals; for example the mixing of alcohol and cocaine producing the dangerous compound cocaethylene (Harris et al., 2003). The use of cocaine and ecstasy mixed with alcohol has been found to lead to toxic effects to the blood and increased pressure on the heart, as well as substantial neurological complaints (Cole et al., 2003; Pennings et al., 2001).

Similar to single drug use, polydrug use has been found to be most common amongst 16-35 year olds that regularly visit nightlife settings such as bars and nightclubs (Hoare & Moon, 2010). In a study of adults attending dance music events in Scotland, it was found that 92.6% of participants had used more than one drug during the previous year, and this was more likely to occur in clubbers, with 66.3% of participants reporting that they mixed drugs at dance music events (Riley et al., 2001). Research has shown that the prevalence of polydrug

use in nightclubs in America is increasingly high. A study of club drug users in New York found that 91.7% of participants indicated having previously used two or more substances at the same time, with substances being most commonly mixed with ecstasy (Groves et al., 2009). Similarly, a study of Canadian rave attendees found that 80% of participants reported poly substance use at their most recent rave event that they attended; with cannabis and alcohol found to be the most common substances to be mixed with psychoactive drugs (Barrett et al., 2005).

Some studies have identified polydrug use as a significant risk factor to tourists and travellers (Bellis & Hale, 2000; Benotsch et al., 2006; Downing et al., 2011; Hughes et al., 2009). In a study of those visiting bars and nightclubs in Ibiza, 31.9% of participants reported using more than one drug during their stay; of those using ecstasy, nearly a third also used amphetamines and 97.3% drank alcohol. With high frequencies of drug use measured over the period of the holiday, this suggests that drugs were being used at the same time (Bellis & Hale, 2000). Nevertheless, studies have yet to identify the reasons and motivations for use of multiple substances.

A potential risk of polydrug use is that individuals are often unacquainted with the consequences of mixing particular drugs and therefore may be more susceptible to serious health problems, such as overdose (Bellis et al., 2009). Additionally, users may be unaware of the potency of the drugs that are being mixed and consumed, and the potential reactions from mixing particular substances. This may be especially relevant in foreign resorts whereby tourists may consume unknown substances, and may have a lack of knowledge of health services (Bellis et al., 2003). Some links have been shown between polydrug use on holiday and increased levels of violence and risky sexual behaviour. In a cross sectional study of British holidaymakers to Ibiza and Majorca, polydrug use was found to be associated with violence and unprotected sex abroad, with over a third of participants having used more than

one substance on holiday (Hughes et al., 2009).

Aside from the findings identified, existing literature on polydrug use in tourists predominantly focuses on gay men who use substances for sexual purposes (e.g. Benotsch et al., 2006; Darrow et al., 2005; Drumright et al., 2006). A study of gay men holidaying in Florida found that individuals taking sexual performance enhancing drugs like Viagra and Levitra were more likely to simultaneously use psychoactive substances, for example marijuana, poppers and ketamine (Benotsch et al., 2006). Nevertheless, polydrug use needs to be highlighted as an important characteristic of all substance users in holiday destinations and must be identified in both homo and heterosexual users.

2.1.5. Legal highs

A recent concern is the use of ‘legal highs’ by young people in the UK; substances with altered chemical structures that enable them to avoid being classified as illegal under the Misuse of Drugs Act 1971. Commonly branded as spices, natural herbal plant and other synthetic substances, legal highs are flooding the drug markets in the UK and being sold legally on the internet due to the fact that they circumvent current legislation, which makes them easily obtainable to young people (Winstock & Ramsey, 2010). However, only recently the UK government has passed the ‘Psychoactive Substances Act 2016’ as an attempt to control this phenomenon, therefore the effects of the legislation are unknown.

When a ban is put on a particular new substance, it is easily replaced by something else, due to the range and variety of compounds available on the ever growing market (Brandt & Sumnall, 2010; Winstock & Ramsey, 2010). New emergent drugs are growing in popularity in nightlife economies in particular, an example being the mass growth of mephedrone use in UK nightclubs until this substance was classified as illegal in April 2010 (Measham et al.,

2011, Winstock et al., 2010). However, in this ever changing industry it is proving increasingly hard to keep up with the amount of new compounds being produced and sold that are avoiding legal classification. Additionally, the composition of legal highs that are ordered from the internet can differ so drastically that the levels of toxicity can be unclear, increasing the risks of use (Davies et al., 2010). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has been recently active in monitoring the use of legal highs across Europe in their European Drug Report (2015). However, they recognised that the prevalence of these substances in Europe is hard to measure because of the rapid changes in definitions and legality (EMCDDA, 2015). There are currently no studies looking at the use of legal highs specifically in holiday environments, therefore the risks and prevalence are still unknown.

2.1.6. Binge drinking and drunkenness

Binge drinking or heavy episodic drinking is the consumption of large amounts of alcohol over short periods of time, often with the intention of becoming intoxicated. The modern binge drinking ‘culture’ has been noted as a specific problem for youth in the UK, as drinking to the point of intoxication is widely seen as a weekly leisure activity (Measham, 2004; Measham & Brain, 2005; Szmigin et al., 2007). Therefore, nightlife industries are continuing to cater for the demand for low price drinks and offers that promote large scale consumption (Measham & Brain, 2005). Yet, it is unknown whether this ‘binge drinking’ culture attracts visitors from overseas to the UK, or whether it is a deterrent.

Binge drinking is known to contribute to major health problems, such as chronic heart and liver problems and increases in those seeking help for alcohol addictions (Rehm et al., 2003; Room et al., 2005). The most recent available UK figures have shown that hospital admissions for alcohol related illness or injury are continuing to increase, with 1,008,850

admissions alone in 2012/13, a figure which is double that in 2002/3. Attributable illnesses across all ages included most commonly alcoholic liver disease and mental health disorders, followed by hypertensive and cardiac diseases (Eastwood, 2014).

Research in young people in the UK has highlighted that misuse of alcohol can lead to negative social outcomes, such as violence and unintentional injury. Findings from the 2013/14 British Crime Survey found that 53% of victims of violence believed that the perpetrator was under the influence of alcohol at the time (Office for National Statistics, 2015). A contributing factor to violence in the UK has been identified as ‘pre-loading’ or ‘pre-drinking’; consuming alcohol, usually at home, before a night out. In a study of young people in the UK, it was found that ‘pre-drinkers’ were 2.5 times more likely to have been involved in a fight, and were also four times more likely to consume 20 or more units of alcohol on a night out. Those drinking 20 or more units were also found to be more than twice as likely to be sexually molested (Hughes et al., 2008). Ultimately, research has shown that heavy drinking is substantially contributing to the number of people visiting health services, such as Accident and Emergency departments (Hughes et al., 2008; Measham & Brain, 2005; Quigg et al., 2010).

Alcohol continues to be related to negative sexual health outcomes across the world and particularly in young people, with heavy drinkers more likely to report larger numbers of sexual partners and unprotected sex (Connor et al., 2013; Scott-Sheldon et al., 2010; Townshend et al., 2014). Of concern, findings from a British sexual behaviour probability study found that female heavy drinkers were more likely to report abortion in the past five years than non-heavy drinkers (Aicken et al., 2010).

There is a growing body of research about binge drinking cultures in holiday destinations, and the issue has been highlighted in a number of recent studies (Bellis et al., 2007; Briggs et

al., 2011a; Hesse et al., 2008, 2009, 2012; Theocharous et al., 2015; Tutenges et al., 2012; Tutenges, 2009; Sonmez et al., 2006; Van de Luitgaarden et al., 2010). In particular, British tourists have been found to consume high levels of alcohol whilst on holiday (Bellis et al., 2007; Hughes et al., 2011). In a study of young holiday-makers of different nationalities, British tourists showed the greatest frequency of drunkenness compared to any other nationality (Hughes et al., 2011). This behaviour may not differ greatly from the behaviours of some young people whilst at home, yet, one major problem with drinking alcohol on holiday, especially in foreign countries, is variation in alcohol measures and strength, which may differ from home country standards (Bellis et al., 2002). This can lead to unpredictable consequences for the consumer.

Similar to drug use findings, excessive drinking whilst abroad has been found to be influenced by peer group pressure and socialisation with other heavy drinkers, and is a common feature in group holiday activities (Hesse et al., 2008, 2012; Sonmez et al., 2006; Theocharous et al., 2015; Thurnell-Read, 2012; Tutenges et al., 2012). This means that drinking can be exacerbated far beyond levels of alcohol consumption at home. Danish holiday companies that operated in Sunny Beach, Bulgaria, were found to verbally instruct tourists to behave excessively and let go of their inhibitions, and provided activities such as risqué shows and drinking competitions (Hesse et al., 2008). Consequently, results of this study showed that 58.8% of tourists drank 12 or more units a day on the party package holiday, compared to 29.4% who were not on the party package holiday. Heavy drinking has also been identified as an important and expected feature of 'stag tourism' amongst groups of males as a sign of masculinity and ritual identity (Thurnell-Read, 2011; 2012). Drinking on holiday has been found to be more concentrated over the short time young people are abroad. A study of British backpackers in Australia found that the proportion of participants drinking

five or more times a week rose significantly from 20.7% in the UK to 40.3% in Australia (Bellis et al., 2007).

Drinking games in particular have been shown to be an activity that is conducive with excessive alcohol use and binge drinking on holiday (Andrews, 2005, 2006; Hesse et al., 2008). In a study of tourist behaviours in Palma Nova and Magaluf, Mallorca, Andrews (2006) describes how youth package holiday tour operators organise drinking competitions whereby if you are to disobey the rules of the game you may have to 'down' a drink and buy another one, or face a penalty. In such games, holiday reps are able to exercise power over the tourists in ensuring that everyone is intoxicated. Moreover, the study highlights that many of the organised entertainment nights and activities revolve around alcohol use.

Excessive alcohol use has been shown to contribute to cases of violence and injury on holiday (Bellis et al., 2002; Calafat et al., 2013; Hughes et al., 2008, 2009, 2011; Tutenges & Hesse, 2008; Tutenges, 2009). A study of young British people visiting the Balearic Isles found that 91.6% of those who had been involved in violence were under the influence of alcohol at the time (Hughes et al., 2009). Studies have also shown an association between excessive drinking on holiday and sexual risk taking, for example unprotected and regretted sex (Bellis et al., 2008; Benotsch et al., 2006; Downing et al., 2010; Sonmez et al., 2006). Research among American spring break students found that around half of male participants reported having sex as a direct result of drinking (49%), and 36% of both male and female students reporting having not used a condom as a result of heavy drinking (Sonmez et al., 2006). Similarly, in a study of gay men travelling to popular tourist resorts in America, it was found that excessive alcohol use was strongly related to having anal sex, having unprotected anal sex, having unprotected anal sex with multiple partners, and not asking partners about their HIV status (Benotsch et al., 2006).

As well as the effects on the individual, research has yet to show the effect that excessive drinking patterns may have on health services abroad, in particular on sexual health services and emergency departments (Sonmez et al., 2013). Binge drinking is a growing concern in holiday resorts, especially for short and long-term effects on the health infrastructure. There are studies that focus on recruitment to illicit drug use in holiday destinations (Bellis et al., 2003, 2009; Segev et al., 2005); however, there is a lack of research highlighting recruitment to excessive alcohol consumption within holiday resorts and the after effects this could have on return from time spent abroad.

2.1.7. Sexual behaviour of tourists

Increased sexual activity on holiday has been noted in a variety of studies of different holiday locations (e.g. Berdychevsky & Gibson, 2015; Hughes & Bellis, 2006, Hughes et al., 2009; McNulty et al., 2010; Sonmez et al., 2006). Findings from Australia in particular have noted an increase in sexual partners and partner change in long-term travellers (Hughes et al., 2009; McNulty et al., 2010). A study of British backpackers in Australia found an increase in sexual partners from 0.3 per four-week period in the UK, to 1.0 per four week period in Australia, with 40.9% of participants reporting inconsistent condom use (Hughes et al., 2009).

Similarly, in studies of international patients in Australian sexual health clinics, backpackers have been found to report a higher number of partners in a three-month period than any other patient type (McNulty et al., 2010).

Sexual behaviour abroad can differ from that at home for a variety of different reasons, for example being away from restrictions such as jobs and parents and having increased opportunities to meet new potential sexual partners (Apostolopoulos et al., 2002; Bellis et al., 2003, 2009; Eiser & Ford, 1995). Such activity has been found in females to be motivated by

the need for thrill seeking, empowerment, experimentation, fun and decreased inhibition (Berdychevsky & Gibson, 2015). One of the most significant influences on holiday sexual behaviour is seen to be the anonymity of resorts, providing a release from concern over sexual reputation that may be found at home (Thomas, 2005). Sexual risk taking on holiday may also be facilitated by the type of holiday that is chosen or the type of travelling companion, for example, back-packing with a long term sexual partner (Berdychevsky & Gibson, 2015), or travelling with a large group of males (Thurnell-Read, 2011; 2012).

Levels of casual sex during time spent abroad can be affected by the expectation or intentions of individuals, as well as prior experience of casual sex and the holiday environment (Bloor et al., 1998; Maticka-Tynedale & Herold, 1999; Maticka-Tynedale et al., 2003; Ragsdale et al., 2006; Sonmez et al., 2006). For example, tourists may make pacts with groups of friends about the type of sexual behaviour they will take part in whilst on holiday (Maticka-Tynedale et al., 2003; Sonmez et al., 2006). In a study of women holidaying in Costa Rica, it was found that women who expected to have casual sex were almost 12 times more likely to obtain condoms prior or during their holiday than those who had no expectations for sex (Ragsdale et al., 2006). Sexual risk taking can also depend on individuals' perceptions of risk. In a study of young females' perceptions of sexual risk taking in tourism, it was found that the sexual activities that were seen to be the riskiest were unprotected sex with an unsteady partner and sex with multiple partners (Berdychevsky & Gibson, 2015).

Significant levels of unprotected sex have been found in holiday destinations, causing concern for health services both at home and abroad (Bellis et al., 2004; Hughes & Bellis, 2006, 2009; Rogstad, 2004). In particular, a high-risk group are casual workers; a study in an international nightlife resort found that 65.5% of workers who had sex reported unprotected sex, compared with 40.4% of holidaymakers (Hughes & Bellis, 2006). However, there is only quantitative evidence to support this, therefore a lack of understanding of the reason behind

such behaviours in this particular group of travellers, which would rely on a more qualitative enquiry. Such high levels of unprotected sex can contribute greatly to the spread of sexually transmitted diseases and HIV whilst abroad (e.g. Carter et al., 1997). Additionally STD transmission can lead to health concerns such as infertility and pregnancy complications in females. This has substantial implications for health services that are left to deal with the societal costs (Abdullah et al., 2004). Nevertheless, it has been suggested that resorts may lack the sexual health treatment services needed to cater for larger amounts of tourists (Bellis & Hale, 2000). This could prevent tourists from being able to access health clinics abroad for potential diagnosis of sexually transmitted diseases, therefore contributing to an extended incubation time before people receive treatment on return home (Lockie et al., 2000). Nonetheless, there are no existing studies that have explored the utilisation of health services abroad for sexual health purposes. Although this may be quite niche, it has been identified that long-term travellers such as backpackers and casual workers are more sexually active populations and reside in holiday destinations for longer periods of time than short term tourists.

Individuals may intend to use a condom at all times, however levels of unprotected sex can be influenced by the type of sexual partner, the availability of condoms and the control of the individual over the sexual experience (Bloor et al., 1998; Maticka-Tynedale & Herold, 1999; Ragsdale et al., 2006). For example, women who indicated embarrassment in talking about sex or condoms were found to be significantly less likely to initiate condom use with new sexual partners abroad (Ragsdale et al., 2006). The increased chance of unplanned or spontaneous sexual encounters on holiday may also contribute to a lack of contraception use (Abdullah et al., 2004). Moreover, as mentioned later in this review, the use of drugs and alcohol may alter the decision making process (Bellis et al., 2004; Hughes & Bellis, 2006; Hughes et al., 2009; Hughes, Downing et al., 2009; Sonmez et al., 2006).

Many travellers may take part in casual one-off sexual experiences; holiday relationships can often be short-lived and therefore sexual relationships accelerated (Thomas, 2005). In an ethnographic study in Ibiza, it was found that the drinking strip in San Antonio was a highly sexualised arena full of strip clubs, prostitutes and promiscuous activity between tourists and casual workers. This created an environment whereby sexual risk was both heightened and normalised due to increased exposure to new potential sex partners and the sex industry (Briggs et al., 2011b). Several studies have suggested that unprotected sex abroad may arise due to increased chances of unexpected or unplanned sex with new sexual partners (Abdullah et al., 2000; Hughes & Bellis, 2004). Individuals may have sexual contact with casual partners who have already had sex with a number of people during their stay, due to increased opportunities for casual sex abroad, and therefore partners that may have a higher prevalence of STDs (Abdullah et al., 2004). In a study of backpackers in Australia, it was suggested that higher rates of partner change may occur due to increased opportunities to network with other backpackers and form social and sexual relationships in hostels and entertainment venues targeted at travellers (Hughes et al., 2009; McNulty et al., 2010).

Studies have identified that the type of new sexual partner encountered can contribute to the level of sexual risk an individual faces whilst abroad (Cabada et al., 2003; Hawkes et al., 1995; Mercer et al., 2007). In a study of international travellers to Peru, of those who had sex, 54.3% had sex with fellow travellers, 40.7% had sex with a local resident, and 2.1% had sex with a commercial sex worker. However, only 69.3% of participants that had sex used a condom, greatly increasing the chance of high risk STD and HIV transmission from partners outside their country of origin, and exemplifying the mobility of sexual health risks (Cabada et al., 2003). Type and origin of sexual partners can also affect people's perceived risk of STD and HIV transmission and the chance that they may take part in casual sex whilst abroad (Mercer et al., 2007). For example, it has been suggested that British backpackers may

perceive the local and travelling populations in Australia to be characteristically and culturally similar to people at home; therefore, they may be more likely to have sexual partners in Australia than Africa and Asia (Hughes et al., 2009). For that reason, part of the problem can lie in the interaction between high and low risk STD and HIV groups, something that requires further research in order to deliver effective preventative measures at all levels and across destinations.

More recently, research has focused upon the sex industry in popular holiday destinations frequented by young people, in Ibiza (Briggs et al., 2011b) and Bulgaria (Hesse et al., 2011). This research highlights the popularisation of sexual activities such as visiting strip clubs or using prostitutes whilst on holiday. In a study of young people (aged 16-30) visiting Bulgaria, it was found that 12.5% of male respondents had reported having paid for sex, and nearly half (48.2%) had visited a strip club during their stay (Hesse et al., 2011). In an ethnographic study of young people in Ibiza, participants appeared to be aware of the heightened risk of STD and HIV transmission from sex with prostitutes and strippers; nevertheless it was seen as quicker and easier than forming sexual relationships with female tourists over the short time they were in Ibiza, and it satisfied their immediate hedonistic needs (Briggs et al., 2011b). Such transactions are of particular concern for STD and HIV transmission cases that may return home to the UK, placing a further burden on home health services.

2.1.8. Substance use and sex

Illicit drugs and alcohol can be used as tools to facilitate sex, raise confidence and to help loosen inhibitions (Bellis & Hughes, 2004; Bellis et al., 2008; Hughes et al., 2009; Thompson et al., 2005). In a study of gay men and their use of 'club drugs', it was shown that substances were used as aphrodisiacs to enhance sexual confidence, desire and emotional closeness with

partners (Drumright et al., 2006). Cannabis in particular has been found to be used to enhance sexual arousal, whereas amphetamines, ecstasy and cocaine have been found to be used to prolong sexual encounters (Bellis et al., 2004, 2008).

Nevertheless, substance use may cause loss of control and reduce people's ability to make informed decisions about sex (Bellis et al., 2008). This can lead to unprotected or regretted sex on holiday, resulting in the spread of sexually transmitted diseases and unwanted pregnancies (Carter et al., 1997; Rogstad, 2004). In a study of holidaymakers to the Balearics, it was found that unprotected sex was associated with using four or more types of illicit drugs on holiday (Downing et al., 2011). A study of American students on a spring break holiday found that decisions about sex and condom use were negatively influenced by alcohol and drugs. Of those who had sex on spring break, 68% of participants reported that they regretted having sex, whilst 63.2% of males and 67.5% of females reported never using a condom after drinking (Sonmez et al., 2006). Risk can be further increased if individuals are partaking in sex with high-risk groups such as sex workers. A study of young British holidaymakers in Ibiza found that alcohol played a large part in the facilitation of sexual encounters with prostitutes and strippers, the majority of whom were from countries of high HIV/AIDs risk (Briggs et al., 2011b).

Research has shown that drug and alcohol consumption is related to the number of sexual partners a person may have whilst abroad (Bellis et al., 2008; Benotsch et al., 2006; Hughes & Bellis, 2006; Hughes et al., 2009). In a study of backpackers in Australia, it was found that illicit drug use was independently related to having casual sex with multiple partners (Hughes et al., 2009). Similarly, in a study of British casual workers in Ibiza, it was found that those who used amphetamines during their stay were more likely to have had multiple sexual partners (Hughes & Bellis, 2006). Illicit drug users have also been identified as being more likely to have had five or more sexual partners in the previous 12 months; particularly

cannabis, cocaine and ecstasy users (Bellis et al., 2008). Such increase in sexual partners leads to the question of increased risk of STD and HIV transmission.

Increased drug and alcohol use and bar and nightclub attendance has been found in many studies to be an indicator for risky sexual behaviour whilst abroad (Bellis & Hughes, 2004; Hughes & Bellis, 2006; Hughes et al., 2009; Hughes, Downing et al., 2009; Sonmez et al., 2006). For example, British backpackers in Australia that visited bars and nightclubs were found to have an increased chance of having unprotected sex or sex with multiple partners, with the odds of those having sex 3.5 times higher in those who frequently drank alcohol (Hughes et al., 2009). For that reason, further research is needed into holiday destinations that are particularly associated with nightlife, with a high volume of bars and nightclubs, such as Ibiza.

Studies have identified that homosexual men in particular use illicit substances to facilitate or enhance sexual encounters, and are therefore at significant risk (Benotsch et al., 2006; Darrow et al., 2005; Drumright et al., 2006). In a study of gay men visiting popular resorts in North America, those using poppers, ecstasy and ketamine were found to be more likely to have had unprotected anal sex on holiday. The number of unprotected anal sex acts and unprotected sexual partners was also associated with increased alcohol use (Benotsch et al., 2006).

Despite the use of substances to facilitate sexual activity, studies have also shown that consumption of alcohol and drugs can reduce sexual abilities. Individuals may be dissuaded from having sex on holiday, either because they are too intoxicated or, or are simply disinterested in sex after consuming substances (Elliott et al., 1998). Individuals may have to use other substances to mitigate the effects of drugs and alcohol, and to increase their sexual performance. A study of gay men visiting holiday resorts in Delaware and Florida, USA,

found the use of drugs and alcohol to cause problems such as erectile dysfunction, and therefore that performance enhancing drugs, like Viagra and Levitra, are also consumed to confound these effects (Benotsch et al., 2006). However, in using illicit substances to prolong sexual encounters, this increases the chance of genital abrasions as sex may exceed natural lubrications; therefore increasing the chance of STD transmission (Bellis et al., 2008).

Similar to literature solely on sexual behaviour, existing studies are predominantly quantitative and do not necessarily take into consideration contextual differences in substance use and related sexual experiences. Without identifying factors that may influence the use of substances for sexual facilitation, adequate harm reduction measures cannot be recommended or implemented. The use of drugs and alcohol for sexual purposes must be acknowledged as an important aspect of risk in holiday destinations, and must be factored in when looking at potential health initiatives.

2.1.9. Health initiatives and effects

The secondary aim of this thesis is to explore the utilisation of health services and health needs in tourist environments. Thus, so far the review has identified particular areas of risk that are contributing to increased health problems in holiday destinations.

The review has demonstrated that health risks can be varied in different holiday destinations and subjective to the type of traveller. There are many variables that may contribute to levels of risk behaviours in individuals, for example, their duration of stay, number of people they are travelling with and social norms of other travellers in the holiday destination (Abdullah et al., 2004). However, the type of holiday environment and immediate infrastructure can play an important role in protecting individuals from harm. For example, unfamiliar surroundings and language barriers can contribute to difficulties in individuals accessing healthcare in

foreign countries (Bellis et al., 2002). Similarly, services may not necessarily be targeted at tourists and may only cater for local residents; yet on the other hand, services in holiday resorts may only be for tourists as nationals may not inhabit the tourist areas. Therefore, it is vital that tourists are provided with knowledge of facilities such as accessible health centres and targeted literature in holiday destinations in their own language that meets their needs.

Tourists are at an increased risk in foreign countries due to differing customs, culture and climate. Health services may be stretched and unable to deal with annual influxes of tourists, particularly in resorts with a small local population (Bellis et al., 2000). Alcohol measures and strength may be different abroad (Bellis et al., 2002; Hughes et al., 2011) and drug markets may vary along with substance strength and ingredient (Bellis & Hale, 2000, 2002; Hughes et al., 2011). Laws and legislation on alcohol and drug use may be unfamiliar in different destinations; therefore individuals may also be at an increased risk of prosecution (Hughes et al., 2009, 2011). Travellers may be at a greater health risk due to hotter climates which can lead to such issues as dehydration and sunburn; which can be further amplified by drug and alcohol use (Bellis & Hale, 2000; Bellis et al., 2002, 2007; Hughes et al., 2011). Furthermore, accessing condoms and emergency contraception may prove problematic in foreign countries (Bellis et al., 2002).

Nevertheless, individuals may be more likely to take part in risky activities, such as casual sex with strangers, if the perceived level of risk to their health is low (Abdullah et al., 2004). This can be affected by contradictory health messages or lack of messages from particular tourism sectors about the dangers of excessive alcohol and drug use, and the related sexual health risks. For example, communities that benefit from tourism have been found to deny the presence of sex related tourist behaviours so as not to jeopardise the popularity of the destination (Abdullah et al., 2004). Thus, holiday resorts may encourage activities such as binge drinking and other irresponsible behaviours in order to promote a 'hedonistic'

atmosphere where anything goes and ultimately maximise profits in their leisure industry (Cabada et al., 2003; Hughes et al., 2011). This creates a problem whereby tourists maybe less informed about health risks and are therefore less able to make informed decisions about their behaviour. Therefore tourists may often find themselves in a position where the authorities in the country they visit are little concerned with their health; but for the duration of their stay their behaviour is not of concern to authority figures back home (Hughes et al., 2011).

Previous studies have exemplified pre-travel prevention strategies, such as the distribution of literature and advice to young people before they travel abroad (Cabada et al., 2003; Crougths et al., 2007; Hamlyn et al., 2007; Paz et al., 2004). However, different levels of success have been shown, highlighting the potential need for different approaches to dissemination of health literature. A study of travellers from the Netherlands and Belgium found that people who had received advice about STDs and condom use were less likely to expect to have casual sex on holiday, yet were more likely to carry condoms (Crougths et al., 2007).

However, in a study of longer-term travellers to the Tropics, the use of a pre-travel brochure about substance use failed to decrease rates of drug use (Paz et al., 2004).

Studies have proposed that travel literature and advice needs to be specifically tailored and targeted at certain types of young traveller (Bellis et al., 2007; Hamlyn et al., 2007; Hughes et al., 2009), yet this is where more evidence is needed to support this, as stated in the third aim of this thesis. In a study of British backpackers, it was shown that young males aged 25 were at the highest risk of substance misuse, therefore appropriate health messages could be developed by profiling this group and providing a tailored approach to literature and advice (Bellis et al., 2007). It has similarly been recommended that health messages and contraception be distributed in environments frequented by young backpackers, such as hostels, bars and nightclubs (Hughes et al., 2009). However, it has been advised that

targeting groups of young people separately can cause barriers for healthcare due to the diversity and cost of their individual health needs (Hamlyn et al., 2007). Nevertheless, without building an evidence base the barriers and costs remain unclear.

In targeting at risk groups, it has been proposed that particular facilitators are utilised to both target health messages, and to influence the behaviour of others. Casual workers and holiday reps/guides are placed in such a position that they may be able to influence more positive behaviours in young tourists, especially as they are often seen as having a high status and esteem amongst tourists (Hughes & Bellis, 2006; Hesse et al., 2008; Tutenges, 2011).

However, holiday representatives (reps/guides) in particular are in such a position whereby they must promote a party atmosphere at the same time as keeping tourists out of danger, so there may be limits to their assistance (Hesse et al., 2008). Staff in bars and nightclubs may be well placed to minimise potential risk behaviours in nightlife environments, for example being wary of substance use and excessive levels of alcohol consumption (Bellis et al., 2002; Hughes et al., 2009). Yet, at the same time, workers have been identified as a group exercising the highest levels of risk behaviour (Briggs et al., 2011b). This leads to the question of if and how workers would be able to be a positive example to tourists, which requires further investigation. Nightlife industries may demand the encouragement of drinks sales to maximise profits in venues. Therefore health promotion must be expressed in such a way that being safe is still an attractive and fun option for tourists in nightlife focused destinations, and relevant to young people (Bellis et al., 2002, 2004).

The responsibility for the protection of tourists may ultimately lie with healthcare practitioners in home countries, with many authors recommending that physicians and healthcare specialists deliver primary information and advice (Crougns et al., 2008; Hamlyn et al., 2007; Mercer et al., 2007; Rogstad, 2004). This could include advice on contraception and the risks of sex abroad (Rogstad, 2004), as well as post-travel advice and treatment for

those who are at risk of STDs and HIV (Crouchs et al., 2008). Nevertheless, although national practitioners can reach patients before and after their holiday, there appears to be a gap in primary healthcare services for tourists whilst they are in resorts, particularly those who inhabit resorts for extended amounts of time. It is questionable if public health authorities in tourist destinations should take responsibility for the healthcare of people visiting, particularly if they are taking part in alcohol and drug related risk behaviours. Yet, it may be felt by both health workers in tourist destinations and tourists themselves that illnesses and injuries may be better treated on return to home countries, especially if the holiday is only for a short time. Similarly, many holiday destinations may feature English speaking pharmacies and doctors surgeries, but these are often private and travellers do not always have the health insurance that is required to cover costs.

Taking all of this into consideration, it is imperative that health messages are able to penetrate the tourism industry in such a way to satisfy all stakeholders. It has been suggested that international nightlife settings must be understood in terms of the types of risks that take place and the needs for health and safety provisions. Risk settings and behaviours must be comprehended by all stakeholders and delineated to gauge a broader understanding of harm reduction measures that can be implemented (Sonmez et al., 2013). As more young people are travelling abroad, it is important that they are protected both at home and in holiday destinations for the whole duration of their stay (Hughes & Bellis, 2004). Therefore it has been recommended that national health protection agencies should work together alongside tour operators, local health providers, airports and experts in sexual health and substance use and other such parties, to provide a holistic and multi-level approach (Abdullah et al., 2004; Hughes & Bellis, 2004, 2009; Sonmez et al., 2013). However, there is little understanding of the utilisation of current health services abroad and the barriers to access. The secondary aim of this thesis is to explore the utilisation of health services and health needs in tourist

environments. Thus, so far the review has identified particular areas of risk that are contributing to increased health problems in holiday destinations.

The review has demonstrated that health risks can be varied in different holiday destinations and subjective to the type of traveller. There are many variables that may contribute to levels of risk behaviours in individuals, for example, their duration of stay, number of people they are travelling with and social norms of other travellers in the holiday destination (Abdullah et al., 2004). However, the type of holiday environment and immediate infrastructure can play an important role in protecting individuals from harm. For example, unfamiliar surroundings and language barriers can contribute to difficulties in individuals accessing healthcare in foreign countries (Bellis et al., 2002). Therefore, it is vital that tourists are provided with adequate facilities such as accessible health centres and targeted literature in holiday destinations in their own language that meets their needs.

Tourists are at an increased risk in foreign countries due to differing customs, culture and climate. Health services may be stretched and unable to deal with annual influxes of tourists, particularly in resorts with a small local population (Bellis et al., 2000). Alcohol measures and strength may be different abroad (Bellis et al., 2002; Hughes et al., 2011) and drug markets may vary along with substance strength and ingredient (Bellis & Hale, 2000, 2002; Hughes et al., 2011). Laws and legislation on alcohol and drug use may be unfamiliar in different destinations; therefore individuals may also be at an increased risk of prosecution (Hughes et al., 2009, 2011). Travellers may be at a greater health risk due to hotter climates which can lead to such issues as dehydration and sunburn; which can be further amplified by drug and alcohol use (Bellis & Hale, 2000; Bellis et al., 2002, 2007; Hughes et al., 2011). Furthermore, accessing condoms and emergency contraception may prove problematic in foreign countries (Bellis et al., 2002).

Nevertheless, individuals may be more likely to take part in risky activities, such as casual sex with strangers, if the perceived level of risk to their health is low (Abdullah et al., 2004). This can be affected by contradictory health messages or lack of messages from particular tourism sectors about the dangers of excessive alcohol and drug use, and the related sexual health risks. For example, communities that benefit from tourism have been found to deny the presence of sex related tourist behaviours so as not to jeopardise the popularity of the destination (Abdullah et al., 2004). Thus, holiday resorts may encourage activities such as binge drinking and other irresponsible behaviours in order to promote a ‘hedonistic’ atmosphere where anything goes and ultimately maximise profits in their leisure industry (Cabada et al., 2003; Hughes et al., 2011). This creates a problem whereby tourists may be less informed about health risks and are therefore less able to make informed decisions about their behaviour.

Tourists may often find themselves in a position where the authorities in the country they visit are little concerned with their health; but for the duration of their stay their behaviour is not of concern to authority figures back home (Hughes et al., 2011). However, what is missing from literature is a picture of available health services in holiday destinations, and how such services react to both the presence of tourists and their activities around drug taking and alcohol use. In the same way, it must be considered that tourists may choose to ignore health messages and warnings, and may have no interest in sourcing available health services as they are there to escape responsibilities and constraints that may be present at home (Eiser & Ford, 1995).

Previous studies have exemplified pre-travel prevention strategies, such as the distribution of literature and advice to young people before they travel abroad (Cabada et al., 2003; Crougns et al., 2007; Hamlyn et al., 2007; Paz et al., 2004). However, different levels of success have been shown, highlighting the potential need for different approaches to dissemination of

health literature. A study of travellers from the Netherlands and Belgium found that people who had received advice about STDs and condom use were less likely to expect to have casual sex on holiday, yet were more likely to carry condoms (Croughs et al., 2007).

However, in a study of longer-term travellers to the Tropics, the use of a pre-travel brochure about substance use failed to decrease rates of drug use (Paz et al., 2004).

Studies have proposed that travel literature and advice needs to be specifically tailored and targeted at certain types of young traveller (Bellis et al., 2007; Hamlyn et al., 2007; Hughes et al., 2009), yet this is where more evidence is needed to support this, as stated in the third aim of this thesis. In a study of British backpackers, it was shown that young males aged 25 were at the highest risk of substance misuse, therefore appropriate health messages can be developed by profiling this group and providing a tailored approach to literature and advice (Bellis et al., 2007). It has similarly been recommended that health messages and contraception be distributed in environments frequented by young backpackers, such as hostels, bars and nightclubs (Hughes et al., 2009). However, it has been advised that targeting groups of young people separately can cause barriers for healthcare due to the diversity and cost of their individual health needs (Hamlyn et al., 2007). Nevertheless, without building an evidence base the barriers and costs remain unclear.

In targeting at risk groups, it has been proposed that particular facilitators are utilised to both target health messages, and to influence the behaviour of others. Casual workers and holiday reps/guides are placed in such a position that they may be able to influence more positive behaviours in young tourists, especially as they are often seen as having a high status and esteem amongst tourists (Hughes & Bellis, 2006; Hesse et al., 2008; Tutenges, 2011).

However, holiday representatives (reps/guides) in particular are in such a position whereby they must promote a party atmosphere at the same time as keeping tourists out of danger, so there may be limits to their assistance (Hesse et al., 2008). Staff in bars and nightclubs may

be well placed to minimise potential risk behaviours in nightlife environments, for example being wary of substance use and excessive levels of alcohol consumption (Bellis et al., 2002; Hughes et al., 2009). Yet, at the same time workers have been identified as a group exercising the highest levels of risk behaviour (Briggs et al., 2011b). This leads to the question of if and how workers would be able to be a positive example to tourists, which requires further investigation. Nightlife industries may demand the encouragement of drinks sales to maximise profits in venues. Therefore, health promotion must be expressed in such a way that being safe is still an attractive and fun option for tourists in nightlife focused destinations, and relevant to young people (Bellis et al., 2002, 2004).

The responsibility for the protection of tourists may ultimately lie with healthcare practitioners, with many authors recommending that physicians and healthcare specialists deliver primary information and advice (Croughs et al., 2008; Hamlyn et al., 2007; Mercer et al., 2007; Rogstad, 2004). This could include advice on contraception and the risks of sex abroad (Rogstad, 2004), as well as post-travel advice and treatment for those who are at risk of STDs and HIV (Croughs et al., 2008). Nevertheless, although national practitioners can reach patients before and after their holiday, there appears to be a gap in primary healthcare services for tourists whilst they are in resorts, particularly those who inhabit resorts for extended amounts of time.

Taking all of this into consideration, it is imperative that health messages are able to penetrate the tourism industry in such a way to satisfy *all* stakeholders. It has been suggested that international nightlife settings must be understood in terms of the types of risks that take place and the needs for health and safety provisions. Risk settings and behaviours must be comprehended by all stakeholders and delineated to gauge a broader understanding of harm reduction measures that can be implemented (Sonmez et al., 2013). As more young people are travelling abroad, it is important that they are protected both at home and in holiday

destinations for the whole duration of their stay (Hughes & Bellis, 2004). Therefore it has been recommended that national health protection agencies should work together alongside tour operators, local health providers, airports and experts in sexual health and substance use and other such parties, to provide a holistic and multi-level approach (Abdullah et al., 2004; Hughes & Bellis, 2004, 2009; Sonmez et al., 2013). However, there is little understanding of the utilisation of current health services abroad and the barriers to access.

2.2. Conclusion

The beginning of the literature review chapter opened with a statement of the aims of the research, which are to:-

- Explore the substance use and sexual risk behaviours of different types of young tourist populations in varying tourism destinations;
- Examine the utilisation of health services and health needs of tourist populations within differing tourist environments to identify gaps in service provision;
- Contribute to an evidence base for tailored health literature and services that are contextually appropriate.

Therefore, at this stage it is important to summarise the existing evidence and identify where the literature review has found evident gaps in knowledge.

Around the world, young people are visiting holiday destinations where sexual risk taking and substance use has become acceptable and expected behaviour, as social norms and boundaries are pushed to new limits (e.g. Eiser & Ford, 1995; Graburn, 2004). The advent of cheap air travel and the growth of city breaks, backpacker holidays and youth package holidays means that destinations are ever more accessible to young people in search of

experimentation and hedonistic pursuits. Subsequently, nightlife resorts in particular are increasingly catering for the demands of young people in providing ‘playgrounds’ for uninhibited partying (Briggs, 2012; Duff, 2008; Sonmez et al., 2013). International travel increases the opportunities for individuals to meet new sexual partners and traveller groups and form what are often casual sexual relationships. This can expose individuals to risk of STD and HIV transmission, and in some destinations those risks may be heightened through sexual relations with local residents and sex workers. Similarly, increased levels of alcohol and illicit drug use have been found in various nightlife related holiday destinations (e.g. Bellis et al., 2007; Hughes et al., 2006). When combining alcohol and drugs with sexual behaviour this only adds to the level of risk as decisions about contraception, for example, can be altered through increased levels of intoxication. As a result, of risky sexual behaviour and excessive substance use, the burden on local and national health services is increasing, as such behaviour leads to instances of violence, STD transmission and other alcohol and drug related illness and injury.

Although this summarises what is occurring in existing public health literature, there are still many gaps that need to be acknowledged and much scope for further research into this area of risk behaviour.

The thesis aims to explore both *different types of tourists* and *varying tourist destinations*. The purpose of this is to link with the third aim to provide a broader *evidence base* for tailored health literature and services that are adequately targeted. As shown in the literature review, there are many studies that have looked at specific destinations (e.g. Bulgaria, Spain, and Australia), and have studied mainly package holiday tourists. Yet, there is a lack of literature acknowledging the diversity of youth traveller groups, such as those who spend time working abroad or those who visit city break destinations. However, it is clear from the small amount of literature on these groups that they are just as active in taking part in

excessive drinking, drug use and risky sexual behaviour as package holiday tourists. Casual workers in particular are a key at-risk group who have been identified as not only setting the trends for behaviour in holiday resorts, but also ideally placed to deliver health messages, yet the actual feasibility of this is unknown.

The purpose of being able to deliver health services and information that is adequately targeted to tourist groups is primarily to decrease the burden on health services in home countries; for example genitourinary medicine clinics (GUM clinics). Without research that both studies the *utilisation of health services* for sex, alcohol or drug related illness or injury in holiday destinations and upon return home, it is unclear as to where services are most needed and where tourism health initiatives could best be applied. At the same time, research is lacking that explores the normalisation of such risk behaviours whilst on holiday, and the effect this will have on their behaviours on return home, for example how recruitment to drug use on holiday could affect patterns of use at home. In which case both pre-travel and during the holiday period could be critical times to deliver health messages that prevent such risk behaviour. Yet few studies have actually followed the tourist pathway all the way through the holiday process, including pre *and* post travel.

As identified earlier in the literature review, although city breaks are an ever-popular type of travel, there are few studies that have actually explored risk behaviours in these settings.

Additionally, with the UK having many popular city break destinations (e.g. London, Edinburgh, Manchester), it is surprising that no such studies exist that look at the behaviours of international travellers within UK cities. However, in order to study the behaviours of tourist groups, one of the most accessible ways may be to look within the UK at the health services we are providing and the types of tourists that visit.

This literature review has identified many existing studies that have taken a positivist approach to risk measurement in holiday destinations, looking at only objective numeric evidence (e.g. Bellis et al., 2003; Hughes et al., 2009). This data is useful for providing a snapshot of the behaviours of large groups and therefore holds much value. However, what is lacking is further exploratory work using qualitative approaches to study cultures of risk in different tourist groups, in order to fully understand why behaviours occur. Moreover, there are few studies that actually use both quantitative and qualitative data to triangulate their findings. Without such data, we cannot make links between findings and check for consistency and validity. What has become clear from the literature review is that there is a lack of evidence from different holiday destinations that links substance use and sexual behaviour in particular in holiday destinations. In the same way, there are existing studies that have identified high levels of drug use in tourists, for example, yet there is a lack of understanding of why individuals choose to take certain substances in different contexts, with findings only speculative at this stage. Additionally, with changing patterns in substance use behaviours (e.g. polydrug use and the advent of legal highs), it is ever more important to understand how such changes are occurring and why.

Taking all of this into consideration, the remaining objectives of the thesis are as follows:-

- (c) Identify a high risk population of young British tourists (casual workers) in a nightlife orientated resort and use mixed methods (quantitative and ethnographic) to measure and describe their levels of risk behaviour around substance use and sexual activity and their utilisation of existing health services;
- (d) Trial a method of identifying the impact of holiday risk taking behaviours on young people's longer term risk taking by implementing a three-stage longitudinal quantitative study among general holidaymakers to measure risk behaviours before, during and after the holiday;

(e) Measure the risk taking behaviours of young tourists visiting the UK as a city break destination by implementing a short quantitative study among national and international visitors to Liverpool, examining levels of substance use, sexual behaviour and utilisation of existing health services.

Chapter 3: Research Methodology

3.1. Research Methodology

The thesis sets out to understand the risk behaviours of different types of tourists in different holiday destinations, including their alcohol and drug use, sexual behaviour, and utilisation of health services. This piece of work is split includes three specific studies; a mixed methods study of young British casual workers in Ibiza, a longitudinal study of a general population of young holidaymakers, and a quantitative study of young tourists visiting a UK city break destination. For that reason, the methodology of each study will be discussed separately. In order to choose the appropriate methodology for studying such populations, the epistemological and ontological aspects of approaches are described.

3.1.1. Theoretical paradigms

The thesis used both positivist and interpretivist paradigms, using both quantitative and qualitative methods. The term *positivism* describes a type of ‘positive science’ based on the idea of having a rational argument built on factual and objective knowledge of the world (Crotty, 2013;19). The term is often associated with the work of Auguste Comte (1798-1857), a self-professed scientist who popularised the term ‘positivist philosophy’ (Hughes & Sharrock, 1990). Comte sought to find a unified synthesis of scientific knowledge that could be used across a number of disciplines, such as mathematics, biology and most importantly sociology. In creating a positivist methodology, the aim was to allow for the measurement of constant relationships, comparisons and causes that occur amongst various phenomena, and to make them solid fact (Crotty, 2013; Hughes & Sharrock, 1990). In which case, the goal of positivism is to make time and context free generalisations.

On an ontological level, positivism believes that there is one single unchanging objective reality that is quantifiable and independent of social construction, therefore approaches to research are more controlled and clear (Carson et al., 2001; Hudson & Ozanne, 1988).

Therefore, the methods can be seen as more systematic and logical, following structured frameworks and techniques, and commonly including a hypothesis. For positivists, theories and questioning must be open to test and be either confirmed or falsified with objective certainty (Hammersley & Atkinson, 2000). Without such certain evidence, it can be said that causal links between variables can only be speculative, particularly in terms of subjective understandings. The benefits and a disadvantage to quantitative research is that in being objective it is also reductionist, however, the use of statistics in public health research in particular has been historically favoured by policy makers (Martin & Felix- Bortolli, 2014). The world can be seen to exist as an empirical entity, made up of concrete objective structures that are independent of abstract and cognitive forces (Gill & Johnson, 1997). It can also be said that research must be empirically verifiable by the researcher and the wider community, therefore fitting better within quantitative frameworks (Crotty, 2013; Walle, 1997). Positivist researchers tend to remain detached from the participants of the research, rather than building relationships or rapport, making a clear distinction between scientific fact and personal feelings or emotions (Carson et al., 2001).

One of the drawbacks of scientific research can be that it does not allow the researcher to follow natural curiosity, intuition and insight (Walle, 1997). The work of Comte in introducing a 'positivist' angle to the study of human/social interactions meant that it could be seen as reductionist in underplaying the importance of free will, choice, morality and the emotions. Therefore, human behaviour can often be seen as only a product of sciences such as biology, chemistry or psychology, surmised by numbers and solid variables rather than more abstract terms. Although positivism can be seen as uncovering the truth and presenting it in empirical means (Henning et al., 2004), Hughes & Sharrock state that '*science can study and describe human values, but cannot assess their ultimate truth*' (1990; 27).

Interpretivism, on the other hand, is based on the critique of positivist philosophy, and the ontology and epistemology that reality is multiple and relative, therefore cannot be interpreted in terms of fixed fact (Hudson & Ozanne, 1988). This means that researchers may adopt an inter-subjective epistemology and ontological stance that reality is socially constructed, therefore there are no correct or incorrect theories. It is often linked to the work of Max Weber (1864-1920) who suggested that human sciences should be concerned with ‘understanding’ people’s interactions and actions; and George Herbert Mead (1934) who emphasised the need to study people’s meanings that they attach to objects and actions that are built through social interaction (Crotty, 2013:67). It adopts the assumption that not all meanings behind data is the same for everyone and that participants have their own perspectives and understandings of their environment. It also infers that all available evidence must be utilised and nothing should be eliminated just because it does not fit within scientific frameworks (Walle, 1997). This means that knowledge is socially constructed rather than objective and fixed (Carson et al., 2001). The approach incorporates a number of idealist approaches including constructionism and phenomenology (Collins, 2010). Constructionism is concerned with the idea that the social world is made of shared meanings that are jointly constructed, such as language; and phenomenology is based on the idea of gaining an understanding of a phenomena by spending time within that society or culture (Crotty, 2013; Sokolowski, 1999). The use of phenomenological qualitative approaches in particular can be useful to look beyond the objectivity present in statistical research, and can allow for more in depth interpretations to be made. A key element is that the social world is studied in its natural state and the researcher can be dynamic within that site, therefore studying phenomena as they really are (Hammersley & Atkinson, 2000).

Rather than searching for objective meaning, interpretivism appreciates differences between people and meanings, and its research process is more naturalistic rather than rational and

structured. This is also reflected in the research methods used that tend to be more personal and flexible, and include a greater level of human interaction. In being flexible, the interpretivist researcher is able to enter the field of study with no fixed research design or structure, therefore data collection can be more fluid and spontaneous (Hudson & Ozanne, 1988). Commonly this type of research is based upon grounded theory, whereby the theory is grounded within the data; therefore, pre-disposed ideas cannot be applied in the initial stages of the research (Glaser & Strauss, 1967). Subsequently, knowledge is collaborative with participants and emergent as themes are drawn from the individual context.

One of the main disadvantages can be that the subjective nature of the research can leave room for researcher bias, and based too heavily on personal viewpoints and values. For that reason, it can be scrutinised and often dismissed for lacking scientific rigour, reliability and representativeness.

The paradigm of mixed methods

As outlined above, positivists in their purest sense maintain that social science enquiry should be objective to ensure that all outcomes are reliable and valid. On the other hand, interpretivists reject positivism on the premise that there are multiple realities that are bound by context therefore cannot be reduced quantitatively (Johnson & Onwuegbuzie, 2004; Doyle et al., 2009). Howe (1988:10) spoke of the ‘incompatibility thesis’ whereby both sets of approaches see their paradigm as correct and ideal, therefore should not be mixed. However, mixed methods can be considered as the ‘*third paradigm*’ or ‘*pragmatic paradigm*’ existing in research domains (Johnson & Onwuegbuzie, 2004; Hall, 2013; Teddlie & Tashakkori, 2009). Mixed methods research is defined as the mixing of quantitative and qualitative research techniques, approaches or concepts in a single study (Johnson & Onwuegbuzie,

2004). Johnson et al recognise mixed methods as *'an approach to knowledge that attempts to consider multiple viewpoints, perspectives, positions and standpoints'* (2007:113).

This recognises that quantitative and qualitative research is very useful when combined, drawing on the strengths and minimising weaknesses. Johnson & Turner (2003) called this the *'fundamental principle of mixed methods'* whereby researchers should collect multiple data in as many ways as possible using a number of strategies and methods in order to result in complementary data. It is also important to note that within all paradigms the shared goal is the study of groups of human beings and the environments in which they exist, therefore one method cannot claim precedence over another. It all depends on which method is most appropriate at that time, as stated by Johnson & Onwuegbuzie:

'researchers and research methodologists need to be asking when each research approach is most helpful and when and how they should be mixed or combined in their research studies' (2004; 15)

Therefore, a qualitative researcher, for example, should be open to use methods that may be more typically quantitative if the research fits better within their framework or is a more workable solution. There is a separation described between types of quantitative and qualitative methodologies; the term 'etic' research has been used to describe rigorous scientific methods that use quantitative means; and 'emic' research to describe qualitative approaches that study cultures and populations on their own terms (Walle, 1997). The separate use of etic and emic methods can be viewed as a trade-off; using quantitative methods on one hand can mean the abandonment of important evidence, and on the other qualitative research can often equal a lack of objectivity and reliability (Walle, 1997). Conversely, the use of a single research method can only capture one particular angle and can

be questioned for its validity, therefore mixed methods can add insights to things that may have been otherwise missed (Johnson & Onwuegbuzie, 2004).

The triangulation of both quantitative and qualitative methods can improve the rigour, validity and generalisability of the results, and allow for a broader range of issues to be addressed by seeking corroboration with different results (Bryman, 2006; Decrop, 1999; Finn et al., 2000). Mixed methods is a way of answering broader and more complex research questions that require multiple approaches, giving the researcher more choice and flexibility to obtain the best possible answers (Mackenzie-Bryers et al., 2014). In the same way, the use of multiple complementary methods can provide stronger evidence for the conclusion of a study, and provide what can be seen as a complete picture (Bryman, 2006; Johnson & Onwuegbuzie, 2004). This is especially relevant when being able to relate findings to theory and practice. Mixed methods can also be used to develop a hypothesis, for example using qualitative methods to create a hypothesis, then use quantitative to test this. Moreover, it can allow for the development and testing of research instruments (Bryman, 2006).

Mixed methods does have its disadvantages in terms of logistics and delivery, for example a researcher may not be able to single-handedly carry out both quantitative and qualitative methods at the same time (Johnson & Onwuegbuzie, 2004). This can also affect the outcome of the research if the researcher does not mix the methods effectively so that they are complementary rather than stand-alone. Mixed methods can also be more time consuming and expensive, and can often lead to double workload (Johnson & Onwuegbuzie, 2004). This means that the researcher may be jeopardising an opportunity to do one more detailed study using only one methodology (Mackenzie-Bryers et al., 2014). Moreover, it can depend on the skills and knowledge of the researcher to be able to mix both quantitative and qualitative methods appropriately (Doyle et al., 2009).

3.1.2. Methods in tourism research

The third aim of the thesis is to contribute to an evidence base around risk behaviours in holiday destinations, and to achieve this it is important to not only explore the findings from existing studies, but also the methodological approaches that have been used. The following will describe different types of approaches and how they have been applied in different tourist settings thus so far (fulfilling objective [b]).

It has been identified that there are three main styles of research that are most applicable to leisure and tourism studies; survey, experimental and ethnographic methods (Finn et al., 2000). Surveys are a positivist approach that are particularly useful in collecting a large amount of data over shorter periods of time. Experimental research involves the testing of variables to measure their effects on one another, such as using a control group (which can be logistically difficult in tourism research). Ethnographic methods are an interpretivist approach that involves the investigation of a culture in its natural setting and the observation of daily life, giving a greater depth to understandings of social interactions.

In tourism research, the collection of data can be difficult due to logistical issues of access to tourists abroad, dispersed populations, and the seasonality of the industry (Cohen, 1984; Urry, 2002). In gaining an understanding of the culture of tourism difficulties can arise in terms of homogenising identities and stereotyping different groups (Smith, 2003). Tourists construct their own subjective perceptions, experiences and understandings of their environments and their individual behaviours whilst on holiday (Apostolopoulos et al., 2002; Sonmez et al., 2006). Further, there can be complex or strained relationships between tourists and locals which may influence the research (Cohen, 1984; Gursoy et al., 2009; Sharpley, 2014).

In a public health setting, the measurement of tourism health behaviours may incorporate different types of data collection, for example the use of national statistics on alcohol and drug use or genitourinary medicine (GUM) clinic data (e.g. Carter et al., 1997). Substance use and sexual behaviour in particular are issues that require a particular type of investigation that is tailored to the research arena in question. The disclosure of information about individuals' sexual behaviour and levels of drug and alcohol use can be inhibited and discouraged if the correct line of enquiry is not chosen and applied effectively (Cunningham et al., 2002; Frenndrich & Rosenbaum, 2003; Mitchell et al., 2007). For example, individuals may be unable to recall instances of past drug use in a short survey questionnaire, yet an informal conversation may generate further memories (Harrell, 1997).

Positivist/ Quantitative approaches

Much tourism research tends to sit within a positivist framework using scientific enquiry and quantitative methods (Finn et al., 2000). Quantitative surveys in particular are useful for gathering large amounts of data that are representative of the study population, to allow for generalisations to be made. Previous studies have used short surveys to investigate tourist behaviours in Spain (e.g. Bellis et al 2003; Hughes & Bellis, 2006), Bulgaria (Tutenges & Hesse, 2008), the USA (Josiam et al., 1998; Sonmez et al., 2006) and Australia (Bellis et al., 2007; Hughes et al., 2009). Some studies have used survey data from tourists from many different nationalities to compare their behaviours around issues such as substance use, violence and risky sexual activity whilst on holiday (Downing et al., 2010, 2011; Hughes et al., 2008). For example, the measurement of predictors of violence in tourists from Germany, Spain and the UK in one Spanish holiday location (Hughes et al., 2008). Other survey methods have been used that longitudinally measure tourists' behavioural changes over time; for example, using a pre or post-holiday survey to measure changes in drug and alcohol intake over a significant travel period to be discussed in the introduction to Chapter 5

(Apostolopoulous et al., 2002; Klunge de-Luze et al., 2014; Vivancos et al., 2011).

Additionally, surveys are useful in providing a tool for comparative research over a number of years, for example in the adoption of previously used and tested surveys in new studies (e.g. Bellis et al., 2003; Hughes & Bellis, 2004).

The distribution of surveys in previous studies of holidaymakers' health behaviours has mainly taken place in airports where large amounts of data can be collected in a short period of time (e.g. Bellis et al., 2004; Hughes et al., 2008, 2011; Tutenges, 2012). This is a particularly useful place in terms of collecting targeted data on different nationalities in one contained area. Other examples of locations that tourist survey data has been collected is in travel or genitourinary clinics (for mainly sexual health based tourist studies; e.g. Carter et al., 1997; Crougths et al., 2008) and hostels (Bellis et al., 2007). This can be dependent on the types of travellers that the survey wants to reach (e.g. backpackers), and the particular health issue that is being studied; for instance, holiday violence studies may take place in hospitals if this was more appropriate for data collection. When researching tourists as a moving population it is common to use convenience or targeted sampling techniques to ensure a large and substantial sample where participants are all congregated in one place for a period of time.

Interpretivist/ Qualitative approaches

Qualitative research methods may include interviews (structured and unstructured), focus groups, or participant/non-participant observation.

Ethnography/participant observation

Many tourist-based studies have used ethnographic methods to study populations of young travellers in holiday resorts (Andrews, 2005, 2012; Briggs et al., 2011a; Briggs, 2013; Sonmez et al., 2013; Thurnell-Read, 2011). Hammersley and Atkinson (2000) view the term

ethnography quite liberally, describing it as the use of particular methods to covertly or overtly view people's lives. It has been adopted in public health research as a tool to understand the social and cultural contexts of health and people's beliefs and attitudes towards personal health (Poole & Geissler, 2005). The use of ethnography may be seen as unreliable due to the fact that the observations of the researcher may be subjective and inconsistent (Finn et al 2000). For that reason, the researcher must assess and reflect upon the impact that they might have had on the research (Bernard, 1994). One of the biggest advantages to the use of ethnography in public health research is that it can advise the implementation of 'culturally appropriate interventions' (Poole & Geissler, 2005).

Some tourism studies have used a combination of qualitative ethnographic methods, such as observations, interviews and focus groups (Briggs et al., 2011b; Urielly & Belhassen, 2006). In a previous study of young tourists in Sunny Beach, Bulgaria, an ethnographic method of non-participant observation was adopted (Tutenges & Sandberg, 2013). However, the author of this study identified that he may have come under criticism for using non-participant observation rather than embedding himself and participating in the tourist culture. Yet, as identified by Spradley (1980) and Bernard (1994), when taking part in ethnographic observation the level of participation into the culture and environment can vary depending on the situation and opportunities to embed oneself. Nevertheless, this flexible use of participant observation can lend itself well to environments where the researcher may have to take on both an insider and outsider role (Bernard 1994; Corbin-Dwyer & Buckle, 2009; Gregory & Ruby, 2011).

Interviews and focus groups

The use of focus groups can be seen as an efficient and convenient way to understand the attitudes of particular groups in a given time-frame and in one particular location (Bloor et

al., 2001; Morgan, 1998). The use of focus groups can be especially important in comprehending groups' perceptions and discourses used towards particular subjects (Morgan, 1993); such as groups' priorities, motivations and opinions (Berg & Lune, 2013). Interviews, as well as focus groups, can be a vital tool for testing the validity of surveys and quantitative analysis and to check for consistency in participants' answers. Interviews can also be used to probe further into questions used in surveys (Berg & Lune, 2013; Sofaer, 2002). They can come in the form of formally structured, semi-structured or completely unstructured interview types; all of which can vary in flow of conversation (Berg & Lune, 2013).

“...the premise of the interpretive analysis is that the interviewees' accounts reflect the subjective perceptions of their experiences, rather than an 'objective reality' of the examined phenomena”

(Urielly & Belhassen, 2005:241)

Interviews can be implemented face to face or using a telephone, which can be an effective way of interviewing larger numbers of people, or those who are not accessible face to face. However, the use of interviews and focus groups can be criticised as their success can be dependent on the skills of the researcher in being able to guide such processes (Grobel, 2004; Sofaer, 2002). Such skill is needed to deliver open and closed ended questions in an appropriate manner so as not to cut off participants mid discourse and to generate natural responses.

Previous studies looking at tourist behaviours have primarily used focus group and interview techniques to collect data (Briggs et al., 2011a; Carr, 2002b; Ragsdale et al., 2006; Thomas, 2005; Wickens & Sonmez, 2007). A study of young people holidaying in Torquay used both interviews and recall diaries (Carr, 2002b). The diaries were used a method of encouraging participants to consider and think more deeply about their holiday behaviours before they

took part in an interview. This meant that recall of experiences and memories were more reliable. Similarly, in a study of females' sexual behaviour in Tenerife, interviews and focus groups were used in a time frame after the holiday which meant that experiences could be successfully recollected (Thomas, 2005). Focus groups were used to complement the interviews and focus the themes that were drawn from them.

Mixed methods approaches

Previous studies have used mixed methods approaches to measure and understand the behaviours of tourists in nightlife orientated holiday destinations (Elliott et al., 1998; Hesse et al., 2008; Theocharus et al., 2015; Tutenges 2012, 2013). In a study of Danish youth visiting Sunny Beach, Bulgaria, a mixture of ethnography and a quantitative survey was used to build a whole picture of the research arena (Tutenges, 2012). This mixed method approach was used as it was felt by the author that existing nightlife tourism research was at that time overshadowed by quantitative methods, and that ethnography had been relatively overlooked as a tool for understanding the lived experiences of participants of nightlife tourism. Similarly, in study of young travellers to a Mediterranean dance related holiday resort, participants were issued a set of questionnaires pre and post-travel, and asked to take part in interviews throughout their time on holiday (Elliott et al., 1998). The interviews were structured around questions on the questionnaire, therefore the aim of the authors was to expand individual responses and triangulate the findings to check for validity.

3.1.3. The application of approaches to my own research

As identified there are existing studies based solely on the behaviours of tourists in holiday destinations that describe the exploits of tourists and their cultural practices (e.g. Andrews 2004; Urry, 2002). Yet, with the advent of public health concerns in this area, such as sexual

health and substance use amongst tourists, methods are required that can also effectively measure the health behaviours of holidaymakers. Methods are needed that numerically measure risk behaviour, but also gain a social, cultural and environmental understanding of such phenomena. Taking previous studies into consideration it is clear that there are different methodologies which may be appropriate to different contexts. Some studies have adopted quantitative survey data collection (e.g. Bellis et al 2003; Hughes & Bellis, 2004), and others have used solely ethnographic methods (e.g. Briggs et al 2011a). Yet, what are missing is studies that have effectively combined methods to provide comprehensive data. In order to gather data that are both significant and rigorous the triangulation of methods, such as ethnography and surveys, may be the key to developing a deeper and more holistic understanding of this arena of risk.

As previously outlined the research questions for this thesis are as follows:

1. *What risk and health seeking behaviours are exhibited by young casual workers in an international nightlife resort?*
2. *What are the everyday behavioural norms and experiences of casual workers that may affect involvement in risk behaviours and use of health services?*
3. *What changes in levels of individuals' risk and health seeking behaviours take place pre and post travel?*
4. *What risk and health seeking behaviours are exhibited by young travellers visiting a UK city break destination?*

In order to address the research questions particular methodological approaches were chosen that were felt to be most appropriate for generating an adequate amount of data for each study.

Taking the positivist and interpretivist approaches into consideration it is clear that both have their merit in terms of use in a social research framework, however in addressing the first two research questions it was important to be able to measure the behaviour of casual workers both numerically and descriptively. In this way, the quantitative findings are used as a tool for identifying areas that require further in depth exploration with qualitative means. In triangulating the findings from both positivist and interpretivist paradigms, it is hoped that the study will provide a deeper understanding of a phenomena of risk within this population, therefore embracing ‘methodological pluralism’ (Kalof et al., 2008).

The philosophical underpinnings of the study are that young people’s risk behaviour is based on knowledge and perception of risk built upon their experience of the phenomena. A positivist approach was used as the nature of the topic means that participants may find it difficult to articulate their behaviour, or talk openly about sensitive topics like sexual behaviour. In this way a short quantitative questionnaire means that participants are not required to converse with the researcher in any way and answers can be provided via tick box. It was also utilised to gather a large sample over a short period of time that can potentially be used to inform policy (preferring statistical data over qualitative). This allowed for the identification of particular areas of risk, such as levels of drunkenness, which requires further exploration in a phenomenological way.

Nevertheless, in the same way a phenomenological approach was seen as useful for being able to build relationships with participants through spending extended periods of time immersed in their reality. Subsequently, this allowed for a rapport and trust to be built with participants that allowed for the engagement with complex or sensitive issues. In the same way, this approach gave the ability to be flexible with the methods that were used depending on the time, place and researcher/respondent needs. The first study aims to focus on the subjective reality of the casual worker as it appears to them, and as best described and

interpreted by the researcher. A phenomenological approach was seen as most appropriate as a way to understand risk behaviour that is not always directly observable and relies on the recollection of stories and memories. This method also gave the opportunity to understand a multitude of realities and different ways of experiencing life as a casual worker in Ibiza.

Combining both a positivist and interpretivist approach allows for both the identification of risk and an exploration of the causes and effects of risk, both objectively and subjectively. It also meant that the study has provided a structured reflection of a phenomenon that could potentially be replicated in future studies. Although, using an interpretivist approach can jeopardise the reliability and representativeness of a study as it is built on subjective understandings and often bias, the addition of the quantitative study has served to improve the rigour and reliability of findings.

The remaining research questions are:

3. *What changes in levels of individuals' risk and health seeking behaviours take place pre and post travel?*
4. *What risk and health seeking behaviours are exhibited by young travellers visiting a UK city break destination?*

For both of these questions a positivist framework was selected in order to adhere to the nature of each study. The idea for both studies was the collection of large amounts of data to provide findings on areas that have yet to be studied. For example, in measuring risk behaviours before, during and after a period of time spent on holiday the most appropriate way of collecting a large amount of data is to use a longitudinal survey. This is not to say that a qualitative approach would not be useful, however the idea was to collect data in a quick and effective manner that was both not time consuming or expensive to implement. In studying a population of young travellers visiting a UK city break destination, little is

currently known about their behaviour and activities that they take part in during their time in the country. For that reason, a quantitative approach was utilised to allow for the collection of data in one specific area over a short time period.

One of the most important aspects of choosing the methodological approach for each of the studies featured in the thesis was the idea that I did not want to interrupt the flow of an individual's holiday. A holiday is a time for escape and relaxation, away from responsibilities such as work. Quantitative methods were chosen that were not too invasive or time consuming for the participants; and qualitative methods were chosen that were more phenomenological and naturalistic, therefore allowing for spontaneous and unstructured encounters with the study population in their natural settings.

As interpretivist paradigms can be complex and involve the study of multiple realities the following section will provide a more detailed description of the phenomenological approach adopted and the ethnographic methods that were used.

3.1.4. Ethnographic methodology

Part of the reason that ethnography as a method was chosen was due to my previous experience of fieldwork in Kardamena, Kos, (Greece) for my undergraduate studies, as previously mentioned. Ethnographic methods of participant observation had allowed me to immerse myself into the casual worker culture and actually 'be a worker' over a period of six months, both living with and working alongside individuals working in the nightlife arena in Kardamena both day and night. In doing this, I recognised the value of ethnographic research in allowing the researcher to form natural research relationships and work in a fluid and spontaneous manner. What I had found from this previous experience in Greece is that young casual workers can be unpredictable, they don't necessarily stick to any routine and

often work unsociable hours or partying until the early hours. There is a feeling that you have to spend time locating the worker, as they are not always easily identifiable from non-working tourists. In taking on a role of working in a bar in Greece over the summer this quickly allowed me to identify worker groups and places where they might socialise. Using an ethnographic method of participant observation allowed me to and socialise with workers in Kardamena, not only as a researcher, but as a friend; breaking down any barriers and allowing a natural rapport to occur with participants. The use of surveys and short interviews may have highlighted my status as a researcher as encounters would not last very long and relationships may not have continued after the study. However, I felt that the use of participant observation over a lengthy period of time allowed me to follow groups of workers throughout their entire season working abroad and observe the subtler aspects of their behaviour, such as changes in attitudes or the formation of new friendship networks. This was an important tool for building a picture of such a population, their social behaviour and their cultural practices.

In its most conventional sense, classic or 'pure' ethnography demands the full time involvement of the researcher in a culture over a lengthy period of time (Van Maanen, 2011). This time intensive and prolonged fieldwork can be seen to underpin the ability to make claims about ethnographic research's pure-ness and representativeness (Fabian, 2002). Due to the limited research time available the study could not use an immersive and fully participative approach over a prolonged period of time, unlike the previous undergraduate study conducted in Greece. However, it has been posited that there is no 'one way' to conduct ethnographic research, as long as it sits within particular methods of ethnographer participation in the daily lives of participants over an unspecified period of time (Hammersley & Atkinson, 2000). The characteristics of this involve asking questions, listening and watching to collect whatever data possible within that given time frame. In

which case, ethnography requires that researchers make an aesthetic decision about when they feel they have presented a ‘whole’ enough picture of the context that the reader can form an understanding of behaviours presented (Fife, 2005). As the ethnographic study approach was coupled with data from a quantitative questionnaire, this allowed for these mixed methods to be triangulated in such a way to create an adequate picture of casual workers in Ibiza at that specific time and place.

Participant observation

Participatory observation is a basic ethnographic research method that involves the establishment of a rapport within a population. It has been known to allow informants to feel they can conduct typical daily activities that are not affected by the researcher’s presence as the research activities are subtler and covert (Bernard, 1994). It can also ensure that the researcher has gained the most intellectual understanding of a particular context in its natural light. A period of time must be spent observing the unwritten and less obvious norms and behaviours that exist within particular cultures, to be able to represent such behaviours in field notes (Fife, 2005).

There is often a distinction between participant observation, taking part in a culture or society; and non-participant observation, having no particular role within the culture or society (Atkinson & Hammersley, 1994). Participant observation, as a practice, has been said to sit on a spectrum between non-participant and participant (Bernard, 1994; Gold, 1958; Ritchie et al., 2014; Spradley, 1980). Therefore, I would like to posit that my research sat somewhere in between the two poles due to my role as part insider, part outsider, to be discussed further. Spradley (1980) has provided a useful diagram to display the scale to which participation within observation takes place;

DEGREE OF INVOLVEMENT	TYPE OF PARTICIPATION
High	Complete
	Active
	Moderate
Low	Passive
(no involvement)	Non-participant

(Spradley, 1980: 58)

Bernard (1994) emphasised that participant observation is something that must be learned whilst in the field, and the extent to which the researcher may participate will be determined by the researchers' own experiences. For that reason, the structure and processes of the observational period cannot be predetermined before entering the field. It is also true that in qualitative health research in particular we cannot always plan for ethical eventualities that may take place during the research process, especially within different cultural contexts (Iphofen, 2011). We also cannot ignore the 'messy realities' of conducting fieldwork that may bring challenges that affect our methodology and the level to which a researcher can be full participatory in the field (Bhardwa, 2013: 40), for example, difficulties in accessing particular groups.

The position of the researcher

The ethnographic study of Ibiza casual workers involved a 'moderate' level of participation; whereby the researcher sought to maintain a balance of being an insider and an outsider. This meant taking part in a moderate level of activities as an insider whilst still having the capability to be an outsider (Spradley, 1980).

It could be said that all social research involves participant observation as it can be unavoidable to study social phenomena without becoming part of it (Hamersley & Atkinson, 1983). However, in terms of researching casual workers in Ibiza, it was felt that being able to position myself as both an ‘insider’ and ‘outsider’ (Spradley, 1980) allowed for the collection of data on behaviours that would normally be deemed deviant or morally unsound, such as drug use and excessive alcohol use. As a researcher I was distinctly aware that I arrived in the resort with a different set of morals and values to that of the informants, built on my own social class, gender and position as an academic (Bhardwa, 2013). This could be referred to as my own ‘habitus’ (Bourdieu, 2000); the set of dispositions that I have based on my own social and economic place in society. During my undergraduate time working in Greece I may have been more inclined to join in with partying or drinking alcohol alongside casual workers and simply ignore any criminal activity taking place, as an adult PhD researcher my moral standards had changed somewhat. I no longer saw drinking alcohol excessively as exciting or attractive, I could not understand the novelty of consuming unknown illicit substances, and was generally more informed and knowledgeable about the consequences of risk behaviour to the health of individuals. I also felt a sense of responsibility to the University that my PhD is affiliated with, and the need to behave in a way that would be deemed ‘appropriate’ for a professional researcher. Bhardwa, in her research in nightclub settings stated her feelings about being a researcher in saying;

‘While I did not want to be dressed in formal clothing in a club, I needed to present myself as a researcher there to do a job and not as a clubber on a night out, therefore reinforcing the dichotomy between work and leisure’

(2013:49)

In conducting research in the nightlife setting of Ibiza I shared similar feelings that were somewhat confused by my want to be an ‘insider’; yet although I wanted to dress informally

I did not feel comfortable wearing the clothing of an Ibiza worker (typically a bikini top and shorts).

This detachment from the activities and appearance of casual workers immediately set me aside from the population that I wished to study, therefore limited the amount of participation within their culture. Hammersley and Atkinson (1995) have described this as a result of 'culture shock' whereby the researcher is immediately confronted with a culture that may be alien to them. However, as a person who had previously worked in a holiday destination with young British people it was less of a shock and more of a decrease in tolerance to this type of behaviour. Yet, I had an understanding of how such behaviour is legitimised in such liminal spaces where hedonistic behaviours are both encouraged and expected.

When walking around the resort of San Antonio and taking observations, the researcher becomes an 'insider' as she may look no different to any other tourist or casual worker, but also an outsider as they are a researcher. When observing casual workers on the beach or by the pool I was an insider and my research was covert, however when speaking to casual workers I was an outsider as my identity as a researcher would be revealed in most occasions. Yet, as highlighted by Calvey (2008) overt and covert research can often be on a moral continuum where the boundaries of being an insider and an outsider can often be blurred. For example, there may be instances where a natural conversation occurs where the status of the researcher may not be revealed, but field notes are recorded. There can also be instances where the logistics of being a researcher may inhibit the level to which a person becomes an insider, for example having to carry recording devices or notepads in spaces where this would be abnormal materials to carry (Bhardwa, 2013).

As highlighted by Andrews (2005) there can be a degree of 'role play' involved, whereby the researcher is able to enact activities such as sunbathing, dancing or playing games in order to fully appreciate a culture of tourism. Coffey calls this '*identity work*' whereby ethnographers can present multiple identities in the field (1999; 4). This has also been referred to as having a 'partial insider status' where the researcher attempts to make the unfamiliar familiar, and tries to create distance between personal interests and the interests of others in the field (Measham & Moore, 2006:16). Yet, when engaging with particular populations it may be more appropriate for the researcher to disclose their identity, so as not to be expected to take part in activities such as drinking alcohol or taking drugs. In terms of this study, prioritisation was given to observations, not just because of the ease of being able to 'stand back', but also that 'looking' at informants can be a powerful research tool in itself (Andrews, 2005). I was not only interested in the way that casual workers interacted with each other, but also the way that workers performed in the environment which may have directed their experiences around risk behaviour.

The only exception to this feeling of outsider-ness was when I was given the opportunity to spend time with casual workers who I classed as friends. During my time spent doing casual work in Kardamena, Greece, I had spent a great deal of time with a group of young females who had decided to travel to Ibiza to work the year after, and had worked there each summer since. They were living in San Antonio, Ibiza at the time of my PhD research, therefore were able to grant me access to their social networks and I was able to spend time with them in more informal settings such as their apartments. During this time, I felt like less of a researcher and more of a person hanging out with acquaintances, which in turn proved fruitful for the research process as became more relaxed and unaware of my own research status, and the collection of data was more fluid and encounters lengthier. Without such contacts, access to the casual worker population may have been a lot less productive over the

short time that was spent in Ibiza over the fieldwork trips, therefore contributed to my findings significantly.

In terms of studying the substance use and sexual behaviours of casual workers, this exemplifies where in research it may not be appropriate or ethically sound to participate in a culture that is characterised by deviant or risky behaviour. Within previous studies, researchers have been known to take part in such activities as drinking alcohol alongside participants within cultures characterised by drinking (Briggs et al., 2011b; Blackman, 2007; Joseph & Donnelly, 2012; Moeran, 2005; Wilson, 2005), or taking illicit substances in nightclub research settings (Thornton, 1995). Such 'insider' behaviour has been adopted as a way to establish 'credibility, rapport and trust' with informants (Briggs et al., 2011b). Nevertheless, this method of immersion questions the ability of the researcher to take part in meaningful exchanges, the credibility of field notes, and most importantly the safety and vulnerability of the researcher and participants (Joseph & Donnelly, 2012; Nordentoft & Kappell, 2011). For that reason, I chose not to take part in alcohol use behaviours whilst in Ibiza, even though this may have highlighted my status as an 'outsider' in scenarios such as bars and nightclubs, but it was important to me as a researcher to stick to my own moral standards.

Bhardwa (2013) has highlighted the effect that being a young female can have on conducting research in nightlife settings, especially when alone. She found that she was met with sexual advances and her presence was found to threaten other women who were in venues with their boyfriends or husbands, which restricted her access to young male participants. Andrews also described this feeling of 'estrangement' in the fact that as a lone female researcher it felt alien to be alone when everyone else was in groups or couples (2008:4). As described by Andrews, the nature and direction of fieldwork can be governed by the female researcher position as 'potentially vulnerable' (2005:251). Bhardwa (2013) also underlined that within

research there can be a lot of situations where the researcher has to put themselves in uncomfortable situations in order to collect the data they need. Nevertheless, as a young female PhD student in a foreign country on my own I was ever aware of my limits in going out at night to bars alone, or walking through a quiet area in the dark, and my research was governed by such eventualities.

As well as the positionality of the researcher there is also consideration in literature of the effects of the researcher and ‘the other’ in ethnographic fieldwork, and how this can affect personal identities and relationships with informants (Coffey, 1999). As stated by Coffey:

‘Fieldwork relationships are at once professional and personal, yet not necessarily readily characterised as either...in fieldwork the professional, research relationship has a far more personal quality. It is not enough to simply go through the motions of politeness and professional courtesy’

(Coffey, 1999: 39)

Sometimes known as the ‘Hawthorne Effect’, informants can be known to change their behaviour when a researcher is present, for example, in overstating or understating, or acting differently in social situations. To overcome this, there is a need to be continually reflective of the research process and the researcher must have an awareness of their role. The researcher can also try to bridge the distance between ‘researcher’ and ‘researched’ by remaining flexible with relationships and time spent with participants as an important part of building trust and rapport (Oakley, 2004). The use of ethnography within the thesis will be discussed further in Chapter 4, section 4.5.

After considering the philosophical underpinnings of research methods and the application of methodological approaches to each study within this thesis, the following chapter will introduce the first study of young British casual workers in Ibiza.

Chapter 4: The Ibiza casual worker study

4.1. Introduction

As identified in the literature review, there is an absence of studies that identify casual workers as a specific risk sub-population that has different characteristics to regular tourists. The extended amount of time that is spent in holiday resorts means that they may have an increased level of exposure to nightlife arenas and risk behaviours. This extended stay in resorts means that workers have the potential to normalise behaviours such as excessive alcohol and drug use and risky sexual behaviour. Moreover, casual workers may be more likely to form social relationships and networks with other workers in the resort, sharing experiences of risk and forming new social boundaries. This exposure to risk could be increased further for those who specifically work within nightlife industries such as bars and nightclubs where cheap alcohol is prevalent. Although some quantitative studies have measured the risk behaviours of this group (e.g. Hughes & Bellis, 2004; 2006), there has yet to be any further studies that measure their characteristics in detail, or take into consideration their health seeking behaviours.

This led to the generation of the following ***objective*** and ***research question (RQ)***:

Objective (c): *Identify a high risk population of young British tourists (casual workers) in a nightlife orientated resort and use mixed methods (quantitative and ethnographic) to measure and describe their levels of risk behaviour around substance use and sexual activity and their utilisation of existing health services;*

RQ1: *What risk and health seeking behaviours are exhibited by young casual workers in an international nightlife resort?*

Ibiza is a destination that is synonymous with nightlife related risk behaviour, particularly around substance use. The type of casual worker that inhabits Ibiza could be seen as one of the most extreme in comparison to other destinations, because of the historical reputation of

the island as a hedonistic capital. Workers may have perceptions and expectations for their time spent in Ibiza that may differ from those of workers travelling to other holiday resorts in terms of letting go of inhibitions and escaping from realities at home.

For these reasons, San Antonio in Ibiza was chosen as the location of the study, and young British casual workers were selected as the subjects. In selecting the criteria and purpose for this study, it was felt that in choosing such a sample of workers in this extreme party environment, this could potentially allow a benchmark to be set from which other risk populations could be measured in other hedonistically orientated nightlife resorts. A quantitative method (questionnaire) and a qualitative method (ethnographic fieldwork) was chosen in order to triangulate the data. Each will be described separately.

In further introducing the study, it is important to set the scene. Thus, the following sections give an overview of Ibiza as a popular and unique holiday destination.

4.1.1. A brief history of Ibiza

Ibiza is the third largest of the Balearic Isles situated off the south east coast of Spain, and has a population of approximately 132, 000 residents. Around 4.5 million tourists visit Ibiza annually and tourism makes up 80 per cent of the islands' GDP (Briggs, 2013). The island is a notorious historical reference point for dance



Map of Ibiza (<http://www.ibiza-ibz.airports-guides.com>)

music tourism, and has been discussed in many academic works on topics such as hedonism (e.g. Bennett, 2004; Diken & Laustsen, 2004) and rave culture (e.g. Critcher, 2000; Langlois, 1992; Sellars, 1998). Its growth to global cult status was built through its reputation for

hosting the most original and vibrant club events, bringing the ultimate hedonistic experience to tourists from around the world.

“The result is a seasonal, and primarily hedonistic, trans-national community whose temporal relationships are framed exclusively around the aural and physical pleasures of the club atmosphere as experienced in the exotic setting of a Mediterranean island” (Bennett, 2004:34)

Historically, Ibiza has been noted as a place for people of all religions and backgrounds to meet in a liberated and spiritual environment. In the 1930s, 40s, and 50s it was seen as a refuge for German, Italian and Spanish artists, and associated with freedom from fascism



Amnesia Club, Ibiza (www.amnesia.es)

(Briggs, 2013). It became a popular hangout for hippies throughout the 1950 and 1960s and with this came the advent of parties, hippy communes and the supply of new types of drugs to the island (Garratt, 1998). Especially attractive to young people was the

opportunity to dance until dawn whilst listening to new kinds of music and experimenting with new drugs, such as LSD (Lysergic acid diethylamide) (www.amnesia.es). The nightclubs of Ibiza today started out as small bohemian venues, but as the number of travellers and tourists grew, dance floors and sound systems were added (Garratt, 1998).

Around the late 1960s it was decided by European tour operators that Ibiza would be an ideal place to develop tourism, thus many hotels were constructed and the island started to become commercialised (Briggs, 2013; Garratt, 1998). Around the 1970s, families and young people

began visiting the island on cheap package holiday deals, and with the rise in the number of bars and nightclubs in San Antonio, this attracted large numbers of young people on a tight budget. By the 1980s, nightclubs on the outskirts of San Antonio and Ibiza Town had turned into 'Superclubs'; venues with a large capacity filled with excessive fantasy-like decorations and holding events such as foam parties with DJs, bands and dancers flown in from around the world. These clubs attracted an exclusive clientele of celebrities and socialites and were globally notorious. New types of music emerged from the variety of genres that people were dancing too, most evidently the advent of upbeat 'house music' commonly known as the '*Balearic beat*' (Bennett, 2004). The Balearic beat catered for the rise in the use of ecstasy in Ibiza, with the beats providing a feeling of togetherness heightened by the highs created by substances.

In the 1980s/1990s, house music went global and took over the Ibiza dance music scene, attracting thousands of young tourists to the island who began to enter the more exclusive nightclubs to see their favourite DJs play. Ibiza became a youth package holiday destination that offered a 'custom-made heaven' whereby tourists could escape the drudgery of everyday life in the UK and immerse themselves in a hedonistic environment of dance music and illicit substances (Sellars, 1998). This in turn attracted a rave scene that revolved around experimental and recreational drug use and excessive alcohol use (Briggs, 2013). At the beginning of the twenty first century, the advent of cheap airlines offering budget flights brought further changes to the number of tourists visiting the island for short and long stay excursions; this allowed tourists that were not from particular elites to enjoy the sights and sounds of the island (Briggs, 2013).

Nowadays, Ibiza remains one of the party capitals of the world and British youth in particular flock to the island with the intention of excessive partying (Bennett, 2004; Bellis et al., 2000, 2003; Briggs, 2013). Yet, with millions of tourists visiting annually this has increased

significant problems around anti-social behaviour, crime and drugs, which can be seen as a burden on the infrastructure of the island (Briggs, 2013). This in turn has given Ibiza a particular reputation as being a ‘temporary wild zone’ where ‘hedonistic excess’ is encouraged (Briggs, 2013; Briggs et al., 2011a). In Ibiza, young people have been found to experiment with drugs (Bellis et al., 2000, 2003; Lora-Tamayo et al., 2004), increase their sexual activity (Bellis, 2004; Briggs et al., 2013), and consume excessive amounts of alcohol (Briggs et al., 2011b). Ibiza continues to have a status above other Mediterranean destinations for its ‘culture of experimentation’ with a unique atmosphere created by a particular mix of dance music and narcotics. Ibiza is an epicentre for substances that are used to accompany the beats of dance music, and provide a heightened hedonistic experience (Briggs et al., 2011a, 2013; Lora-Tamayo et al., 2004). The resort of San Antonio, in particular, has historically been noted as a place of excess, where heavy alcohol consumption, drug use and sexual debauchery has been continually accepted and endorsed through its nightlife economy (Briggs, 2013; Sellars, 1998). This means that the Ibiza economy is seen as being completely reliant on ‘a party orientated, summer month only tourism which also buoys the economically stagnant winter months’ (Briggs, 2013: 50).

Ibiza has attracted a lot of media attention in the past couple of decades from UK newspapers and magazines; with articles entitled ‘*Why the party island of Ibiza is a hedonist’s paradise*’ (Frankl, 2009) and is commonly referred to as ‘*Europe’s party island*’ (McMonagle, 2016; Rakhit, 2016). Ibiza has also featured in many famous global dance music songs such as ‘Miami 2 Ibiza’ (Swedish House Mafia) and ‘I took a pill in Ibiza’ (Mike Posner). This only serves to conjure images of Ibiza as an exciting and attractive place to visit for young people who like to party.

Although there are no recent studies, in the past decade quantitative studies in this area have found that risk behaviours such as excessive alcohol use, substance use and risky sexual

behaviour are still a frequent part of everyday life in San Antonio (Bellis et al., 2009; Hughes & Bellis, 2006; Hughes et al., 2009). Further, recent qualitative studies have gone on to solidify the resort's reputation for wild partying, hedonistic exploits and the pushing of social and moral boundaries (Briggs, 2013; Briggs et al., 2011a).

4.1.2. Casual workers in Mediterranean resorts

The following information is based on a literature review of studies of young casual labour working in holiday resorts in and around the Mediterranean over summer seasons. Due to a scarcity of existing literature found on this topic, online forums (www.ibiza-spotlight.com, www.digitalibiza.com) were consulted to gather further information on worker populations specifically in the destination of Ibiza. For the purpose of this study, the review of literature did not include studies on migrant workers who travel to countries for permanent residency and long-term registered employment. For example, studies on the migration of labour populations due to economic crisis or war. Similarly, the review excluded studies on migrant sex workers. This may have served to minimise the amount of literature that was consulted, however it allowed for the review to be more relevant and streamlined to the type of population that is referred to throughout the following study. As previously mentioned, not all studies refer to people who work over summer periods in a holiday destination as a 'casual worker', however for the purposes of this study they will be described as such.

The typical casual worker is a young person, aged between 16 and 30, who finds temporary work in a holiday resort over the summer season, usually for 3-6 months. Workers in the Mediterranean typically include: tourists who, after holidaying in a resort, decide to stay and work; those who intentionally go to resorts to seek work; and those who have previously worked abroad and are returning for another season (Briggs et al., 2011b). As previously

discussed, it is often unclear whether this sub group of young people should be classed as ‘tourists’ or ‘workers’, as many view casual work as a form of extended holiday rather than a period of legitimate and committed employment (Briggs, 2013; O’Reilly; 2000; Rice, 2010). Additionally, their involvement in employment markets can be ambiguous and often short lived (Briggs, 2013). Such populations are often students or from the periphery of their home labour markets, with a lack of commitment or permanence to any position.

Casual workers in European holiday destinations take on many different roles in employment markets within the tourism industry, often dependent on the type of resort and the demand for jobs at that particular time. There are daytime and night-time economies, differing tourist consumption patterns, and most commonly a need for employees that are willing to create hedonistic arenas of excess. In the nightlife industry, people typically work within bars and nightclubs as waiters or bar staff (Hughes et al., 2004). Many take part in promotional representative (PR) work, which includes handing out flyers and enticing customers into premises with drink offers, often through provocative dress and discourse (Sonmez et al., 2013). It is commonplace for bar owners to employ workers who are confident and physically attractive to work in the busy night-time environment (Tutenges, 2011). Bar and nightclub staff typically work long hours for little pay, yet take part in such employment for the benefits of being part of a party atmosphere.

Casual workers may also work for larger youth package holiday companies, accompanying tourists around resorts and providing hedonistic activities and excursions. This type of worker is commonly called a ‘tour rep’ or ‘guide’ (Guerrier et al., 2003; Tutenges, 2011). Tour reps work longer hours per day, and are trained to meet guests at the airport, take tourists on bar crawls, organise drinking activities and be entertaining. However, many of the activities revolve around partying, binge drinking and sexual activity (Guerrier et al., 2003; Sonmez et

al., 2013; Tutenges & Sandberg, 2013). Thus, tour reps generally provide guidance and set the standard for the holiday from the outset.

Casual workers in nightlife-orientated resorts have been found to consume greater quantities of alcohol and illicit drugs than their tourist counterparts (Hughes et al., 2004). Bar and nightclub employers often provide free alcoholic drinks to their staff to encourage them to be energetic and confident, and to engage with customers. Tour reps are commonly required to drink alcohol alongside their customers, and to take part in drinking games and activities (Guerrier et al., 2003; Tutenges, 2013; Sonmez et al., 2013). Similarly, workers have been found to engage in higher levels of risky sexual behaviour than tourists (Hughes & Bellis, 2006). Tour reps in particular have a reputation for facilitating sexual relations with their customers (Sonmez et al., 2013; Tutenges, 2013). Subsequently, workers are exposed to a consistent recreational 'party' atmosphere for longer periods than tourists, leaving them at a greater risk for excessive behaviour (Hughes & Bellis, 2006).

4.2. Quantitative study methods

4.2.2. Questionnaire

In order to answer the research question (1), the quantitative study used a short questionnaire to gather numerical data from casual workers on their behaviours during their time in Ibiza. Data collection took place over a two-week period in August 2009. In an environment where casual workers are busy working and socialising in a fast-paced setting, it was crucial to be able to gather data without interrupting the daily flow of the casual worker environment. Thus, the questionnaire needed to be short to restrict the time needed for completion and enable the recruitment of higher numbers of participants. Questionnaires have previously been used in Ibiza to study both casual workers and tourists (e.g. Bellis et al., 2003; Hughes & Bellis, 2006); therefore, their applicability in this resort had already been proven. Based on these existing tools, the questionnaire was developed to enable the continuation of standardised data collection in this area. However, the questionnaire was street based rather than using an airport location for distribution, as unlike tourists, casual workers' arrival and departure dates are varied and unpredictable. Casual workers can depart on flights from the UK from any airport, and arrive on any day; casual workers may have been difficult to locate as they may look just like tourists; and casual workers were commonly tourists that had decided to stay so did not have immediate intentions of working in the destination.

The questionnaire incorporated previously used questions on casual workers' demographics (e.g. age, gender) and substance use with additional questions included on sexual behaviour and health whilst in Ibiza. The questionnaire looked at the following themes (see Appendix 1):

- The reasons and motivations behind coming to Ibiza, and the type of work that participants were involved in.

- Participants' substance use in Ibiza, and previous use in the UK
- Participants' sexual activity in Ibiza, and their previous patterns of sexual activity in the UK.
- The sexual health of the participants, and their intentions to seek healthcare back in the UK.

Ethical approval was sought from Liverpool John Moores University (LJMU) Research Ethics Committee (see Appendix 2). Ethical approval from authoritative bodies in Spain was not sought as the intention of the study was to focus on British participants only, however this may have strengthened the ethical process and safety and security of the researcher and participants whilst in a foreign country. Spanish ethical bodies will be consulted for future research projects in this area as it cannot be predicted the nationality of participants that may be encountered, especially when using ethnographic methods that require a level of flexibility and fluidity. Spanish participants may have been affected by the researcher's presence, and some conversations with Spanish participants were recorded in note form. The usability of the questionnaire was initially tested on a pilot group of 15 participants aged 16-35 from the North West of England. The pilot group was recruited from students attending LJMU, using a social networking site and a snowballing technique. Pilot participants volunteered to meet at a LJMU library and students individually filled in a questionnaire in a designated private study area. Pilot studies are important as they can 'give advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated' (Van Teijlingen & Hundey, 2002). This in turn increases the likelihood of the study being successful and gives the researcher plenty of time to adjust the study design.

4.2.3. Recruitment

The target sample was British individuals aged 16-35 years old, who took part in casual work in the resort of San Antonio, Ibiza. The age range for the sample was advised by

Professor Mark Bellis and Dr Karen Hughes who have previously implemented a number of studies within youth tourism and public health, and was based on their experience in this field (e.g. Bellis et al., 2000; Hughes & Bellis, 2004, 2006). Potential participants were approached opportunistically in areas frequented by casual workers, such as bars, beaches, pools and worker accommodation blocks. Casual workers (n= 221) were asked if they had time to fill in a short questionnaire and those who had time (n=199) were informed about the nature of the study. Consent was obtained orally from those who were willing to take part (n=182), and all participants were told of their anonymity and their right to withdraw at any time. Consent and refusal rates were recorded on a separate sheet for reference.

Participants were handed a questionnaire (see Appendix 1) on a clipboard, a pen and an envelope. They were then asked to complete the questionnaire while the researcher stood a small distance away. All participants were informed that if they needed any assistance, to immediately contact the researcher. Participants were told to place the questionnaire into a sealed envelope once completed and return this to the researcher; alternatively the researcher arranged to collect the completed questionnaire later that day. All sealed envelopes were returned to the UK at the end of the study period for analysis.

4.2.4. Analysis of findings

The data gathered from the questionnaires were entered into an SPSS database on return to the UK. Data analyses included Chi- Squared and Wilcoxon signed rank tests, followed by logistic regression, which was used to find independent associations between variables (Field, 2000; Gray & Kinnear, 2011). The inclusion criteria for analysis were being a British casual worker aged 16-35 years who had been in Ibiza for less than six months. This last criterion was included to ensure that individuals were temporary casual workers rather than longer stay residents of Ibiza. Consequently, 28 questionnaires were not included due to the

ages being over 35 years and the time spent in Ibiza longer than six months. Three questionnaires were not included as they did not enter any information on substance use or sexual behaviour. The final sample was 171 participants.

Publications

The findings from this study were published in the following peer reviewed journal article (see Appendix 15):

- Kelly, D., Hughes, K. Bellis, M.A. (2014) Work hard, party harder; drug use and sexual behaviour in young British casual workers in Ibiza, Spain. *International Journal of Environmental Research and Public Health*, 11(10), 10051-10061

4.3. Quantitative findings

4.3.1. Characteristics

Table 1 presents participants' demographics and factors associated with their stay in Ibiza by gender. There were no differences between genders in age or length of stay. Of the 171 participants, 47.4% were male and 52.6% female. The mean age was 22.1 years, with two thirds of the survey population aged between 20-25 years old. The questionnaire asked participants how long they had stayed in Ibiza by the time of the survey and how much longer they intended to stay before returning home. Across all participants, the mean length of stay in Ibiza by the time of the survey was 10.3 weeks, with the mean total stay from start to finish being 18.9 weeks. Participants were asked why they had chosen to work in Ibiza, presenting a list of possible reasons for individuals to select (see Appendix 1). Three quarters reported having chosen to work in Ibiza due to its nightlife (73.7%) and music (73.1%), and around a third reported that they had chosen Ibiza for the accessibility of sex (32.7%) and drugs (39.8%). Males were more likely than females to have reported choosing Ibiza for sex, drugs and music (see Table 1).

4.3.2. Type of work

There were no gender differences in the number of seasons previously worked, how participants found work, the type of work casual workers took part in or the hours that participants worked (see Table 1). Nearly half (48.5%) of participants had not previously worked in Ibiza (first time workers); over half (54.3%) came to Ibiza to find work and did not have a pre-arranged job. The majority of participants (85.4%) worked in the nightlife industry for bars or nightclubs, with only 19.9% of participants working in the daytime. Participants worked a mean of 42.2 hours per week, with 59.9% working 35-50 hours. Around two thirds

of participants (62.5%) visited a bar five or more times a week, and 63.7% attended a nightclub 2-4 times a week; there were no differences between genders for participation in nightlife.

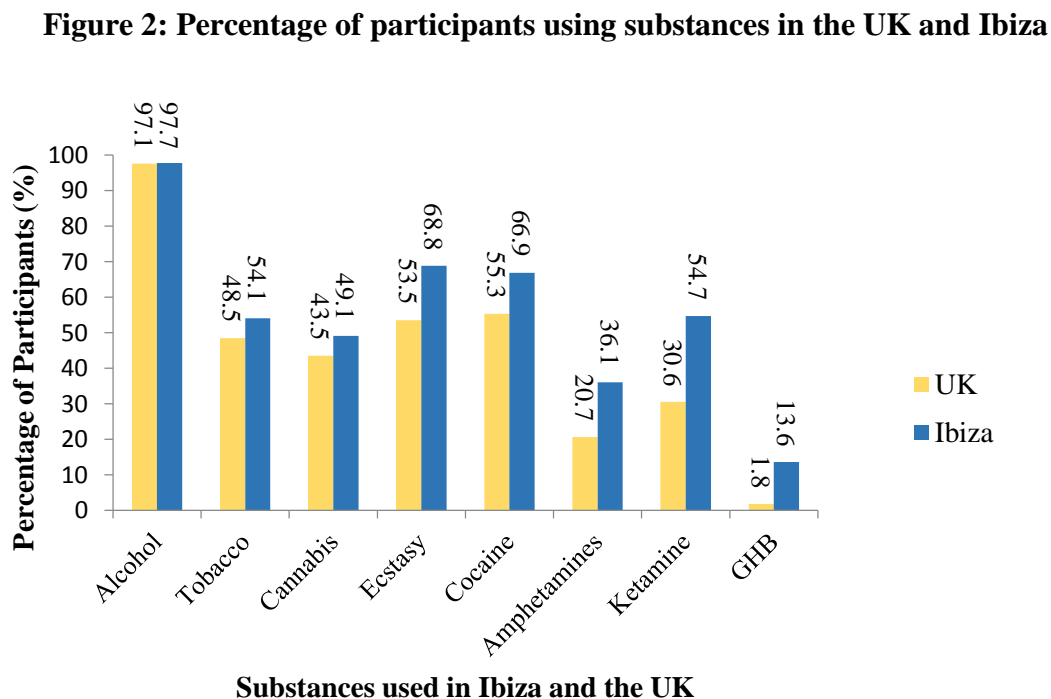
Table 1: Casual worker characteristics

		All		Male		Female		X ²	P
		%	n	%	n	%	n		
Age group	16-19	19.9	34	19.8	16	20.0	18	5.184	0.075
	20-25	65.5	114	59.3	48	71.1	64		
	26-35	14.6	25	21.0	17	8.9	8		
Length of stay by interview	1-5 weeks	14.6	25	11.1	9	17.8	16	1.551	0.460
	6-10 weeks	38.6	66	39.5	32	37.8	34		
	>10 weeks	46.8	80	49.4	40	44.4	40		
Total expected stay	Up to 10 weeks	15.2	25	14.1	11	16.3	14	0.158	0.924
	11-20 weeks	42.1	69	42.3	33	41.9	36		
	>20 weeks	42.7	70	43.6	34	41.9	36		
Worked in Ibiza in previous seasons	No	49.1	83	42.5	34	57.5	46	2.658	0.103
	Yes	50.9	86	57.5	46	44.9	40		
Reason for choosing Ibiza	Nightlife	73.7	126	74.1	60	73.3	66	0.012	0.913
	Weather	71.3	122	69.1	56	73.3	66	0.367	0.544
	Family/Friends	58.5	100	60.5	49	56.7	51	0.257	0.612
	Sex	32.7	56	51.9	42	15.6	14	25.501	<0.001
	Drugs	39.8	68	61.7	50	20.0	18	30.991	<0.001
	Music	73.1	125	84.0	68	63.3	57	9.215	<0.05
Found work	Came to work in prearranged job	33.5	57	35.8	29	31.5	28	0.369	0.832
	Came to find work	54.7	93	53.1	43	56.2	50		
	Came on holiday and stayed	11.8	20	11.1	9	12.4	11		
Days/nights working	Days only	20.1	34	18.5	15	21.1	19	0.634	0.728
	Nights only	37.3	63	35.8	29	38.9	35		
	Days and Nights	42.6	72	45.7	37	39.8	35		
Working for bar/nightclub	Yes	85.4	146	90.1	73	81.1	73	2.774	0.096
	No	14.6	25	9.9	8	18.9	17		
Hours working per week	35 or less	24.6	41	22.5	18	26.4	23	0.357	0.837
	35-50 hours	59.9	100	61.2	49	58.6	51		
	>50 hours	15.6	26	16.2	13	14.9	13		
Frequency of visiting bars in Ibiza	Once a week or less	5.4	9	3.8	3	6.7	6	1.344	0.511
	2-4 times a week	32.1	54	29.5	23	34.4	31		
	5 or more times a week	62.5	105	66.7	52	58.9	53		
Frequency of visiting nightclubs in Ibiza	Once a week or less	17.9	30	15.2	12	20.2	18	0.908	0.635
	2-4 times a week	63.7	107	67.1	53	60.7	54		
	5 or more times a week	18.5	31	17.7	14	19.1	17		

4.2.3. Substance use

Participants were asked about the frequency of their substance use at home in the UK and whilst in Ibiza. The substances listed were alcohol, tobacco, cannabis, cocaine, ecstasy, amphetamines, ketamine and gammahydroxybutyrate (GHB). Participants were also asked if they had used any other form of illicit drug (e.g. a legal high). Measurement of previous substance use in the UK used a scale over the past 12 month period, and a weekly scale was used to measure use during their time spent in Ibiza (see Appendix 1). This allowed for the comparison between previous use in the UK and use in Ibiza and thus how patterns of use had changed whilst abroad (see Figure 2).

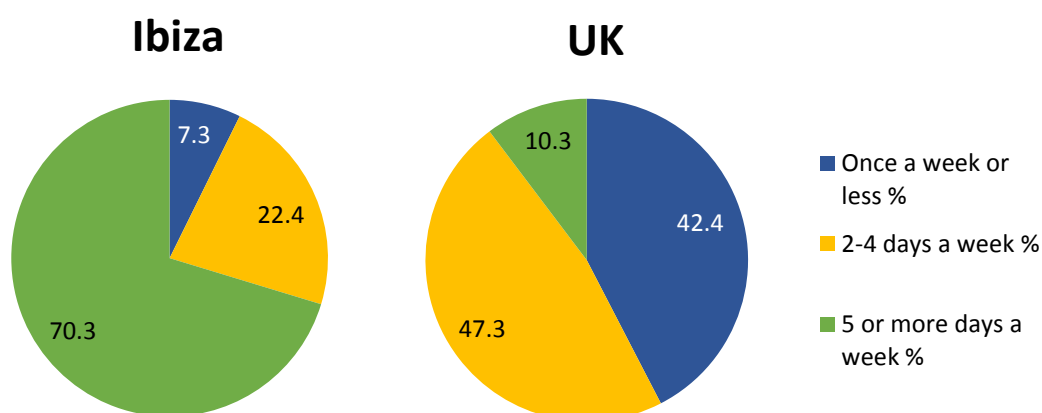
As shown in Figure 2, there was little difference between the percentage of participants that reported using alcohol in the UK and Ibiza, with the vast majority using in both locations; around half of participants smoked in both locations.



Over two thirds (71.2%) of all participants used illegal drugs in the UK, rising to 85.3% of participants in Ibiza. The most commonly used illegal drugs in both the UK and Ibiza were ecstasy and cocaine. There were no participants that reported having used a legal high. There were no differences for in alcohol, tobacco or illegal drug use by gender, age group or seasons previously worked.

Figure 2 shows that across all substances except alcohol the proportion of users was higher in Ibiza than in the UK. This was particularly noticeable for ketamine with an increase in use from 30.6% in the UK compared to 54.7% in Ibiza ($P<0.001$); and in GHB use from 1.8% in the UK to 13.6% in Ibiza ($P<0.01$). Over one in twelve (8.7%) participants reported that they had used MDMA (which is a form of ecstasy, commonly in powder form); yet they had also reported ecstasy use separately, therefore viewing them as separate substances. Similarly, two participants reported that they had not used ecstasy but had used MDMA in Ibiza. For the purpose of analysis reported MDMA use was noted as ecstasy use.

Figure 3: Frequency of alcohol use per week in UK and Ibiza amongst those that used in both locations



The questionnaire examined the changes in frequency of substance use in those who were users in both the UK and Ibiza. Across all substances the frequency of use increased in Ibiza (see Figure 3 and Table 2). The increase in frequency of alcohol use in Ibiza was particularly noticeable (see Figure 3), with just 10.3% of participants using alcohol five or more days in the UK compared with 70.3% in Ibiza ($P < 0.001$). Nearly half of all participants (46.8%) reported being drunk in Ibiza five or more days a week.

Findings in Table 2 shows that while 98.8% of ecstasy users took this drug once a week or less in the UK, in Ibiza around a third (29.8%) used at least twice a week, with around one in ten (10.7%) using five or more days a week. Similar increases were seen for cocaine, amphetamine and ketamine use.

Table 2: Frequency of substance use in UK and Ibiza of those using in both locations

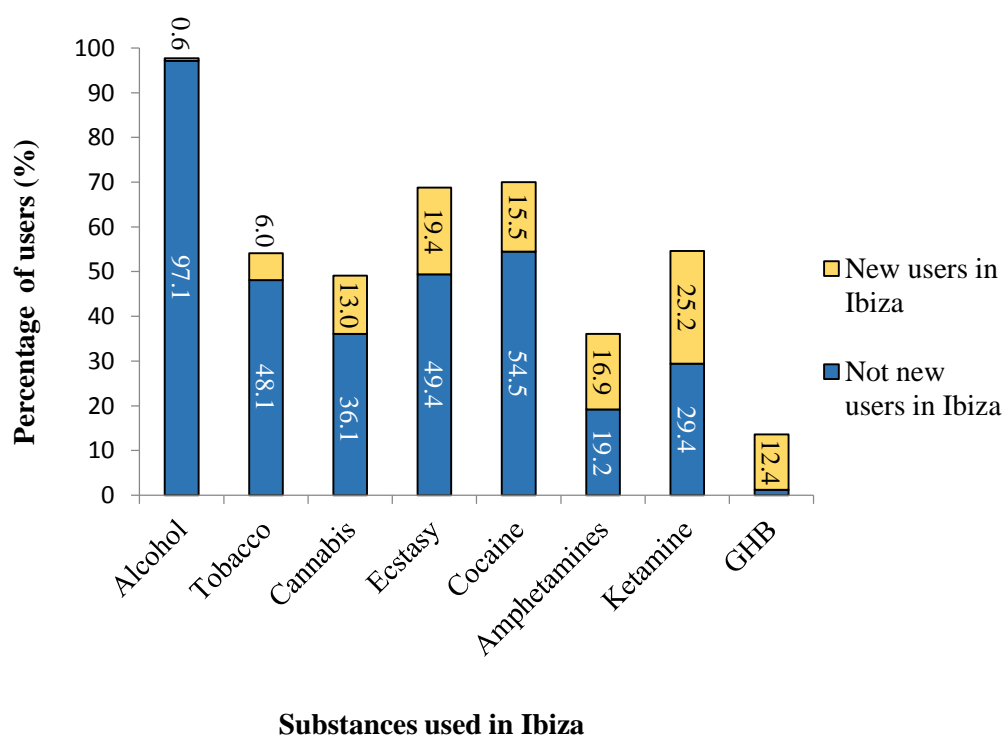
	Tobacco	Cannabis	Ecstasy	Cocaine	Amphetamine	Ketamine
<i>n</i>	81	61	84	87	32	50
Frequency of use UK %						
Once a week or less	19.8	70.5	98.8	93.1	100.0	98.0
2-4 days a week	11.1	18.0	1.2	5.7	0	2.0
5 or more days a week	69.1	11.5	0	1.1	0	0
Frequency of use Ibiza %						
Once a week or less	7.4	59.0	59.5	57.5	62.5	44.0
2-4 days a week	8.6	23.0	29.8	31.0	25.0	40.0
5 or more days a week	84.0	18.0	10.7	11.5	12.5	16.0
X ² between locations	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001

Note: GHB was not included as there was no significance shown

Multiple substance use was common in Ibiza with 74.7% of participants reporting that they had used more than one substance during their stay so far in Ibiza. The high frequency of drug and alcohol use in Ibiza suggests that polydrug use is taking place amongst the worker population.³

A proportion of participants had been recruited or had relapsed into illegal drug use whilst in Ibiza. Of the participants that used illegal drugs in Ibiza, 56.2% reported that they had used at least one illegal substance in Ibiza that they had never used or had not used in the past 12 months in the UK. Around half of participants who used ketamine (46.2%) and amphetamines (45.9%) were recruited to or had relapsed into using these substances. The vast majority (91.3%) of those who used GHB in Ibiza had never used this substance before or had relapsed into use (see Figure 4).

Figure 4: Percentage of substance using participants in Ibiza who were new or continued users by substance type



³ Polydrug use: using two or more illicit substances at the same time to balance or maximise the effects of other drugs or alcohol (see Literature Review for detailed description).

4.2.4. Sexual behaviour

The questionnaire asked participants about their sexual behaviour whilst in Ibiza and in the past 12 months in the UK. Participants were firstly asked if they arrived in Ibiza with a sexual partner or spouse. Following this, they were asked about the number of partners they had in the past 12 months in the UK and how many people they had sex with in Ibiza.

Table 3: Sexual behaviour of all participants in Ibiza and previously in the UK, and of those arriving without a partner and having had sex

Total sample		n=171							
		All		Male		Female		X ²	P
		%	<i>n</i>	%	<i>n</i>	%	<i>n</i>		
Visited Ibiza with partner (%)		13.5	23	17.3	14	10.1	9	1.864	0.172
Had sex in Ibiza (%)		87.4	146	87.3	69	87.5	77	0.001	0.975
Sub sample: those arriving without a sexual partner		n=145							
Had sex in Ibiza (%)		86.9	126	88.1	59	85.9	67	0.148	0.700
Number of sexual partners (%)	0	13.1	19	11.9	8	14.1	11	0.628	0.89
	1	15.2	22	13.4	9	16.7	13		
	2 to 4	42.8	62	43.3	29	42.3	33		
	>5	29.0	42	31.3	21	26.9	21		
Number of sexual partners in last 12 months in UK (%)	0	4.9	7	7.6	5	2.6	2	11.308	0.01
	1	21.0	30	10.6	7	29.9	23		
	2 to 4	56.6	81	57.6	38	55.8	43		
	>5	17.5	25	24.2	16	11.7	9		
Sub sample: those without a sexual partner who had sex		n=126							
Had unprotected sex in Ibiza (%)		50.0	63	47.5	28	52.2	35	0.287	0.592
Number of unprotected partners in Ibiza	0	50.0	63	52.5	31	47.8	32	8.494	0.014
	1	26.2	33	15.3	9	35.8	24		
	2	23.8	30	32.2	19	16.4	11		
Number of sexual partners per fortnight in Ibiza (%)	<1	69.0	87	67.8	40	70.1	47	0.147	0.929
	1 to 2	22.2	28	23.7	14	20.9	14		
	>2	8.7	11	8.5	5	9.0	11		
Had sex with a non-UK resident in Ibiza (%)		30.4	38	32.2	19	28.8	19	0.172	0.679

The questionnaire asked with how many partners had they used a condom, if they had sex that they later regretted, and if they had sex with someone who was not from their country of residence whilst in Ibiza. It also allowed participants to specify if their partners were tourists, casual workers or local residents. This allowed for a comparison of the sexual behaviour of individuals previously in the UK and whilst in Ibiza; and to measure the amount of sexual contact that takes place amongst casual workers, tourists and local residents (see Table 3).

Of all participants, 87.4% had sex in Ibiza. When looking at those who had sex, Wilcoxon signed rank test found that casual workers had significantly more partners in Ibiza than at home: a mean of 0.82 per fortnight in Ibiza compared with 0.14 in the UK ($P < 0.001$). There were no differences in gender for having had sex or the number of sexual partners in Ibiza.

The majority (86.5%) of participants had travelled to Ibiza without a sexual partner or spouse. Of those who arrived with a sexual partner or spouse, 87.0% had one sexual partner or did not have sex in Ibiza. Consequently, analysis of sexual risk taking was limited to those arriving without a sexual partner. As shown in Table 3, 86.9% of the participants arriving without a sexual partner had sex in Ibiza and seven in ten (71.7%) reported sex with multiple partners. Of those that had sex, 50.0% had unprotected sex and 58.7% of these had unprotected sex with multiple partners. Of this subsample, males reported more unprotected sexual partners than females, with around a third of males (32.2%) having multiple unprotected sex compared with 16.4% of females ($P < 0.05$). In chi-squared analysis, there were no associations between sexual behaviour and gender or age group (Table 4). Those who had been in Ibiza longer by the time of interview and those with a longer total expected stay were more likely to have had sex and had multiple sexual partners ($P < 0.05$). Those who chose to visit Ibiza for sex, drugs or music were more likely to have had sex in Ibiza ($P < 0.05$). There were no significant predictors for having had unprotected sex in Ibiza (see Table 4).

Table 4: Characteristics of casual workers and sexual behaviour limited to those arriving without a sexual partner or spouse

			Had sex			Had multiple partners			Had unprotected sex								
			Yes %	X²	P	Yes %	X²	P	Yes %	X²	P						
Gender	Male	88.1	0.148	0.700	74.6	0.517	0.472	47.5	0.287	0.592							
	Female	85.9			69.2			52.2									
Age group	16-19	90.0	0.549	0.760	66.7	0.482	0.786	63.0	2.539	0.281							
	20-25	85.4			72.9			47.6									
	26-35	89.5			73.7			41.2									
Length of stay by interview	1-5wks	81.8	7.543	0.023	50.0	7.345	0.025	61.1	1.556	0.459							
	6-10 wks	79.3			70.7			52.2									
	>10wks	95.4			80.0			45.2									
Total expected stay	Up to10 wks	72.7	7.088	0.029	45.5	9.295	0.010	62.5	2.532	0.282							
	11-20 wks	83.9			71.0			51.9									
	>20 wks	94.6			80.4			41.5									
Worked in Ibiza previous seasons	Yes	91.7	2.858	0.091	65.8	2.584	0.108	51.7	0.127	0.721							
	No	82.2			77.8			48.5									
Reasons for choosing Ibiza	Nightlife	Yes	90.0	3.855	0.050	71.8	0.002	0.964	52.5	1.178	0.278						
		No	77.1			71.4			40.7								
	Weather	Yes	87.7			69.8			48.4								
		No	84.6			76.9			54.5								
	Family/Friends	Yes	89.0			70.7			47.9								
		No	84.1			73.0			55.8								
	Sex	Yes	96.0			76.0			47.9								
		No	82.1			69.5			51.3								
	Drugs	Yes	94.9			74.6			53.6								
		No	81.4			69.8			47.1								
	Music	Yes	91.5			75.5			47.4								
		No	74.4			61.5			58.6								
	Found work	Came to work in prearranged job	95.6			4.822			0.090			80.0	2.717	0.257	34.9	5.970	0.051
		Came to find work	84.1									69.5			58.0		
Came on holiday and stayed		77.8	61.1	57.1													
Working for bar or nightclub	Yes	88.9	3.352	0.067	73.0	0.791	0.374	48.2	1.286	0.257							
	No	73.7			63.2			64.3									
Day/night working	Day only	76.0	4.697	0.096	56.0	4.128	0.127	47.4	1.404	0.496							
	Night only	93.1			77.6			44.4									
	Day and night	86.7			73.3			55.8									
Hours working per week	35 or less	84.8	1.758	0.415	63.6	5.312	0.070	42.9	3.589	0.166							
	>35-50 hrs	90.8			79.3			55.7									
	>50 hours	81.8			59.1			33.3									

4.2.5. Substance use and sexual behaviour

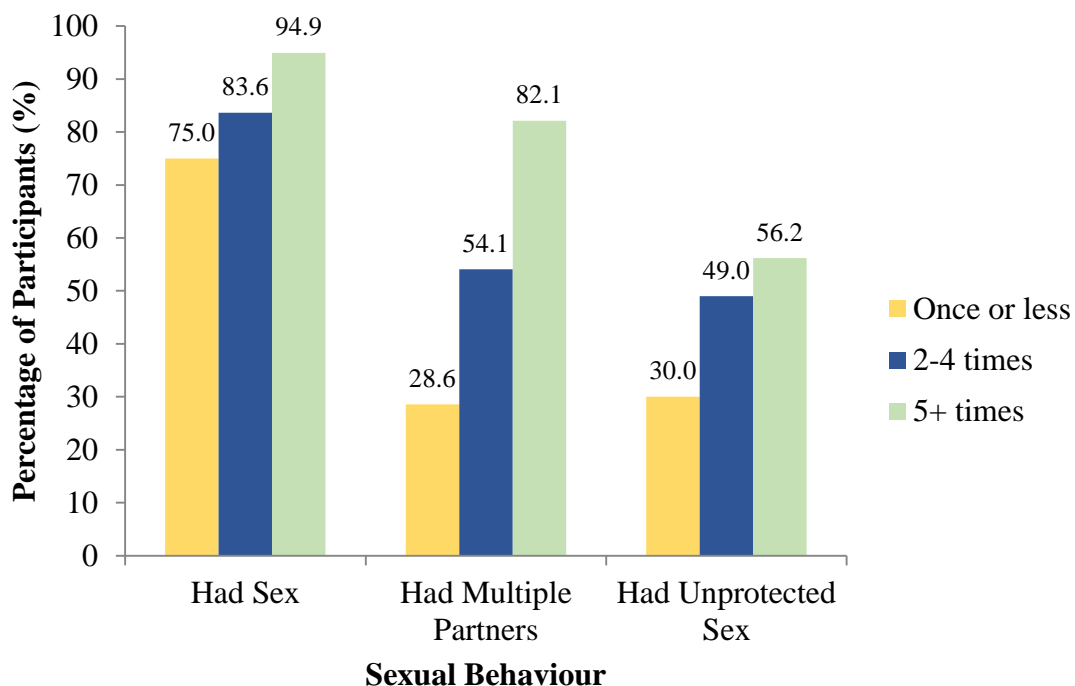
Using chi-squared analysis, the sexual behaviour of casual workers was examined based on their substance use and nightlife behaviours (see Table 5).

Table 5: Sexual behaviour of casual workers by substance use and nightlife behaviour in Ibiza

		Had sex			Had multiple partners			Had unprotected sex		
		%	X ²	P	Yes	X ²	P	Yes	X ²	P
Alcohol	Yes	87.3			72.5			50.0		
	No	66.7	1.101	0.294	33.3	2.226	0.136	50.0	0.000	1.000
Tobacco	Yes	91.0			82.1			50.7		
	No	83.3	1.934	0.164	60.6	8.195	0.004	49.1	0.032	0.857
Cannabis	Yes	91.7			76.4			45.5		
	No	81.9	2.971	0.085	68.1	1.246	0.264	55.9	1.368	0.242
Ecstasy	Yes	89.3			75.7			48.9		
	No	81.0	1.835	0.176	61.9	2.811	0.094	52.9	0.161	0.688
Cocaine	Yes	90.0			77.0			50.0		
	No	80.0	2.726	0.099	60.0	4.422	0.035	50.0	0.000	1.000
Amphetamine	Yes	94.7			80.7			40.7		
	No	81.6	5.182	0.023	65.5	3.899	0.048	57.7	3.548	0.060
Ketamine	Yes	89.3			76.2			53.3		
	No	83.6	1.001	0.317	65.6	1.964	0.161	45.1	0.824	0.364
GHB	Yes	82.4			77.3			42.1		
	No	86.9	0.004	0.947	71.3	0.330	0.566	51.9	0.617	0.432
Polydrug use	Yes	90.2			75.9			48.5		
	No	75.8	4.655	0.031	57.6	4.217	0.040	56.0	0.449	0.503
Frequency of visiting bars										
	Once a week or less	71.4			42.9			20.0		
	2-4 times a week	83.3			71.1			48.6		
	5 or more times a week	91.1	3.822	0.148	75.6	3.553	0.169	53.7	2.234	0.327
Frequency of visiting nightclubs										
	Once a week or less	62.5			50.0			60.0		
	2-4 times a week	91.0			70.8			45.7		
	5 or more times a week	93.1	14.580	0.001	93.1	12.187	<0.01	59.3	2.123	0.346
Drunkenness (per week)										
	Once or less	66.7			38.1			28.6		
	2-4 times	84.0			66.0			45.2		
	5 or more times	94.6	11.767	0.003	85.1	19.081	<0.001	57.1	4.381	0.112

Those who regularly visited nightclubs were more likely to have had sex ($P<0.001$) and had multiple sexual partners ($P<0.01$) in Ibiza. Those who reported polydrug use in Ibiza were also more likely to have had sex ($P<0.05$) and had multiple sexual partners ($P<0.05$). Those who used tobacco ($P<0.05$), cocaine ($P<0.05$) and amphetamines ($P<0.05$) were more likely to have had multiple sexual partners. Those who used amphetamines were also more likely to have reported having had sex ($P<0.05$). Participants who used alcohol and cocaine were found to be more likely to have had unprotected sex ($P<0.001$).

Figure 5: Percentage of casual workers having sexual intercourse, multiple sexual partners and unprotected sex in Ibiza by frequency of drunkenness per week



Drunkenness was associated with having had sex ($P<0.005$) and having multiple sexual partners ($P<0.001$) in Ibiza. The proportion of participants who reported having multiple sexual partners in Ibiza rose from 28.6% in those who were drunk once a week or less, to

82.1% in those who were drunk five or more times a week (Figure 5). The vast majority (89.7%) of those who had unprotected sex reported being under the influence of alcohol at the time; and around two-thirds (71.2%) reported being under the influence of drugs.

To identify factors independently associated with sexual behaviour in Ibiza, logistic regression was undertaken looking at all factors (e.g. demographic characteristics, substance use) significantly associated with sexual behaviour in chi-squared analysis (shown in Table 6). The total expected stay of participants was independently associated with having had sex in Ibiza. Having had sex and having sex with multiple partners whilst in Ibiza was independently associated with the frequency of drunkenness of participants in Ibiza. Using tobacco was independently associated with having multiple partners in Ibiza (see overleaf).

Table 6: Factors independently associated with having had sex and having multiple partners in Ibiza

Had sex in Ibiza		AOR⁴	95% CIs⁵	P
Length of stay by interview	1-5 weeks	Ref		<i>0.078</i>
	6-10 weeks	2.940	0.146 59.230	<i>0.481</i>
	10> weeks	0.277	0.490 1.563	<i>0.146</i>
Total expected stay	up to 10 weeks	Ref		<i>0.023</i>
	11-20 weeks	0.013	0.001 0.290	<i>0.006</i>
	20> weeks	0.181	0.026 1.277	<i>0.086</i>
Visited Ibiza for sex		Ref		
		2.071	0.200 21.459	<i>0.542</i>
Visited Ibiza for drugs		Ref		
		1.796	0.214 15.055	<i>0.589</i>
Visited Ibiza for music		Ref		
		2.227	0.602 8.236	<i>0.230</i>
Amphetamine use		Ref		
		3.801	0.723 19.971	<i>0.115</i>
Polydrug use		Ref		
		0.376	0.084 1.686	<i>0.201</i>
Nightclub attendance (per week)	Once a week	Ref		<i>0.348</i>
	2-4 nights	0.373	0.430 3.259	<i>0.372</i>
	5> nights	1.013	0.116 8.855	<i>0.991</i>
Drunkenness (per week)	Once a week or less	Ref		<i>0.010</i>
	2-4 times a week	0.034	0.004 0.304	<i>0.002</i>
	5> times a week	0.161	0.025 1.033	<i>0.054</i>
Had multiple partners in Ibiza		AOR	95% CIs	P
Length of stay by interview	1-5 weeks	Ref		<i>0.707</i>
	6-10 weeks	0.737	0.104 5.212	<i>0.760</i>
	10> weeks	0.664	0.253 1.743	<i>0.405</i>
Total expected stay	up to 10 weeks	Ref		<i>0.354</i>
	11-20 weeks	0.282	0.040 2.005	<i>0.206</i>
	20> weeks	1.060	0.395 2.846	<i>0.908</i>
Tobacco use		Ref		
		2.657	1.150 6.141	<i>0.022</i>
Cocaine use		Ref		
		1.450	0.378 5.561	<i>0.588</i>
Amphetamine use		Ref		
		2.117	0.820 5.464	<i>0.121</i>
Polydrug use		Ref		
		0.545	0.110 2.695	<i>0.456</i>
Nightclub attendance (per week)	Once a week	Ref		<i>0.306</i>
	2-4 nights	0.293	0.058 1.484	<i>0.138</i>
	5> nights	0.356	0.083 1.527	<i>0.164</i>
Drunkenness (per week)	Once a week or less	Ref		<i>0.000</i>
	2-4 times a week	0.075	0.021 0.272	<i>0.000</i>
	5> times a week	0.278	0.109 0.709	<i>0.007</i>

⁴ **AOR** adjusted odds ratio

⁵ **CIs** confidence intervals

4.2.6. Health information, advice and treatment

The questionnaire asked participants about their use of health services in Ibiza, including: the number of visits they had made to a doctor or hospital; whether these visits had been related to substance use or sexual activity; if they had received any health literature about alcohol, drugs or sex in Ibiza; and their use of sexual health services (pregnancy testing, emergency contraception and sexual health check-ups). The questionnaire also asked if participants intended to receive a sexual health check up on return to the UK.

Just over one quarter of participants (28.9%) had visited a doctor or hospital during their stay in Ibiza; however the majority of visits (62.5%) were not alcohol, drug or sex related. Around a third (34.1%) of participants had received health information regarding alcohol, drugs or sex. Over one in eight (13.3%) participants had required emergency contraception for themselves or their partner and 10.2% had received a pregnancy test in Ibiza. Of participants arriving without a sexual partner and having sex, only 11.2% received a sexual health check-up in Ibiza; however of these 76.2% reported that they intend to receive a sexual health check up on return to the UK.

4.4. Discussion of quantitative findings

The findings from this study have shown that casual workers are a particularly high-risk group of tourists, with study participants reporting high levels of drug and alcohol use, and risky sexual behaviour, over long periods spent in the resort. The most concerning findings are that 85.3% of casual workers had used an illicit substance during their stay; with around half (56.2%) having used a substance that they had never used previously. Moreover, participants were intending to stay an average of 8.5 weeks longer in the resort after the survey, which means that these figures are likely to underestimate the prevalence of drug use and experimentation. Around half of participants reported using ecstasy (53.5%) and cocaine (55.3%) in the UK prior to coming to Ibiza, which is much higher than past year prevalence rates amongst 16-24 year olds in the UK (2009/10, ecstasy 4.3%, cocaine 5.5%, Hoare & Moon, 2010). This highlights that Ibiza is the type of resort that attracts high-risk workers who are already involved in recreational drug use. However, it is clear that being immersed in the Ibiza culture for long periods of time can facilitate further risk taking.

The findings from this study are comparable to those from a previous study on casual workers' substance use and sexual behaviour in Ibiza (Hughes & Bellis, 2004; 2006), which highlights that this population remains a key risk group in this environment. Hughes & Bellis in their 2004 study found that 91.3% of participants used ecstasy whilst in Ibiza, and 87.0% used cocaine. However, their study did not measure levels of recruitment to drug use, and therefore it was unknown how many participants had started using these substances whilst in Ibiza. This was one of the most important findings in this current study, with over half of participants that had used drugs in Ibiza (56.2%) reporting that they had used a drug that they had never used previously. A previous study of young international tourists found that 7.2 % of British tourists and 8.6% of Spanish tourists were recruited to ecstasy in Ibiza; similarly, 5.1% of British respondents had relapsed into ecstasy use after not using in the previous 12

months before their holiday (Bellis et al., 2009). Therefore, it is clear that casual workers are a more 'at-risk' population for recruitment and relapse into drug use than previous findings on tourists.

Although the literature review identified that the use of legal highs in tourist destinations had yet to be studied the findings did not uncover any use of legal highs, therefore this remains an area that requires further exploration. The findings on substance use are important both in developing harm reduction messages that may address drug use; and in terms of the development of policy that recognises that populations of young people who have been recruited to drug use each summer may be returning to the UK with potential recreational drug habits.

The frequency of alcohol use among casual workers rose dramatically in Ibiza with 70.3% drinking on five or more days during their stay compared with just 10.3% reporting this level of use in the UK. Alcohol was found to be a significant facilitator for sexual encounters, with frequency of drunkenness being a predictor of having had multiple sexual partners. Alcohol has been found to decrease inhibitions when it comes to sex and reduce people's ability to make informed decisions about contraception (Bellis et al., 2008; Thompson et al., 2005). Thus, of those who had sex that they later regretted, 98.7% reported that this had been whilst under the influence of alcohol. The literature review highlighted that there had been few previous studies linking the use of alcohol to sexual facilitation, however such findings provide evidence for casual links.

Worryingly, of the 86.9% who had sex whilst in Ibiza, 50% of them had sex that was unprotected; yet only 14.3% of these participants sought any sexual healthcare whilst in Ibiza. The majority of these participants stated that they would wait to receive a sexual health check up on return to the UK. Similarly, only around a third of participants had received any

health information or advice whilst in Ibiza. Such figures require further investigation to identify the reasons behind the non-use of health services in Ibiza. Hughes & Bellis in their 2006 study of sexual behaviour of casual workers in Ibiza found that 80.5% of those arriving without a sexual partner had sex in Ibiza, with 65.5% of those having had unprotected sex. Although the figures from this most recent study show slightly lower levels of unprotected sex, this still highlights that no successful interventional changes have occurred in minimising sexual health risk. Similarly, the findings showed that tobacco use was independently related to having had multiple sexual partners in Ibiza. Andrews (2011) highlighted in her findings a case where the sharing of cigarette was used as a tool to facilitate a sexual encounter. The male informant had invited a female back to his hotel to 'share a cigarette' which then led onto them having a casual sexual encounter (2011: 207). Smoking can be seen as a sociable practice as many people gather in groups to smoke cigarettes, leading to new friendships, which could potentially be new sexual partners (Mercken et al., 2009, 2010).

In terms of theoretical understandings of risk behaviour in Ibiza, young casual workers could be classed as 'sensation seekers' in the way that they are taking part in new or heightened activities that are both risky and illegal (Lepp & Gibson, 2008). Nevertheless, it is unclear through numerical findings alone whether the adoption of such behaviours is a result of being away from home and responsibility; or a direct result of being in an environment where risk is promoted and accepted, or both. It could be said that taking part in risky sexual behaviour, such as unprotected sex, with multiple casual partners is a sign that inhibitions are lowered in an environment such as Ibiza. This is further exemplified in the increased number of sexual partners measured compared to previous partners at home in the UK. This 'situational disinhibition' of casual workers could be very much related to situational factors and the environmental context whereby individuals may feel as though they are a different person

whilst in this environment (Eiser & Ford, 1995). Similarly, people may feel detached from responsibilities at home and the judgement of peers in a liminal space like Ibiza, therefore may be more likely to take part in risk activities such as drug taking (Shields, 1991). In their 'liminoid' state, casual workers could be said to seek pleasurable and experimental experiences, without necessarily having to think of the consequences of their behaviour (Shields, 1991; Turner, 1982). Such theoretical understandings of casual worker behaviour will be discussed in further detail in section 4.8.

Casual workers have been identified as a potentially higher risk group than non-working tourists due to increased length of time spent in San Antonio, Ibiza. As shown, the length of stay of participants was independently associated with having had sex in Ibiza. However, what distinguishes casual workers from non-working tourists at this stage is that they are in an environment with high levels of participation in risk behaviour such as drug use and excessive drinking for sustained periods of time, without necessarily seeking any health advice or treatment.

Limitations of method

This study focused only on British casual workers in the resort of San Antonio and was conducted opportunistically, and therefore is not representative of British casual workers abroad in general.

Recruiting casual workers for the short quantitative questionnaire proved relatively successful; however, some participants were hesitant to take part. This was due to a number of factors such as lack of time, disinterest or embarrassment at the nature of the topic. The sensitive nature of the study topics (sexual activity and substance use) may have affected compliance rates as well as answers to the quantitative questionnaire. Participants may have been hesitant to disclose information about their substance use due to the fact that drug use is

illegal, or they may have an inability to recall their use (Freundrich & Rosenbaum, 2003; Harrel, 1997). Similarly, participants may have been reluctant to give information about their sexual activity due to the fact that sexual promiscuity could be seen as deviant behaviour (Cunningham et al., 2002; Fenton et al., 2001; Mitchell et al., 2007). To address this, participants were re-assured that all information would remain confidential and would not be disclosed to any other parties, and no information was required that may link their identity in any way to the data.

Gender related findings may have been affected due to the differing behaviours of males and females, for example in exaggerating, hiding or understating the information given. This issue could have additionally been influenced by peers who were present in the nearby area where questionnaires took place. Such behaviour has been shown in previous studies (Briggs, 2013; Thurnell-Read, 2012) whereby male individuals have been affected by the presence of their friends and pressure to brag about their behaviour, or stay silent due to fear of being judged by their peers. This in turn could lead to the distortion of findings if encounters are not recorded truthfully. Subsequently the chosen locations for questionnaire distribution may have affected the participants' willingness to disclose certain information. In all cases, participants were encouraged to fill out the questionnaires in a private area, and to speak to the researcher only if they required assistance. Participants were also encouraged to step away from their friends or groups to reduce peer pressure and influence from others. Individuals were made aware that they could withdraw from participation at any point if they felt uncomfortable with the location or content of the questionnaire. Participants were similarly informed that their answers may benefit future health initiatives for casual workers, therefore to answer as truthfully as possible.

One of the main difficulties found in implementing the study was the logistics of recruiting workers due to the fact that many worked and socialised at night and slept throughout the

day, therefore contact with casual workers was reasonably limited. As a sole researcher, it was not safe to conduct research at night, further limiting research hours per day. Casual workers who were around in the daytime were often working and therefore did not have time to take part in the study. To overcome this problem, workers were asked if they had time to meet at a certain location later that day to take part in the survey, however this resulted in many no-shows and thus wasted study time. Initially this caused problems, but to overcome this issue, local bar owners and residents were consulted to find the common whereabouts of available worker populations in the daytime. When collecting data about attendance at bars and nightclubs, the questionnaire did not distinguish between work and leisure time. For example, individuals may have reported attending a bar five or more nights a week, yet they may work in a bar and count this as attendance. Further use of questionnaires would need to distinguish between these differences in nightlife participation.

4.4.1. Conclusion

A high-risk population of casual workers in San Antonio, Ibiza, was identified and their behaviours were successfully measured using quantitative methods (partially fulfilling objective [c]). In terms of answering the initial research question (1) '*what risk and health seeking behaviours are exhibited by young casual workers in an international nightlife resort?*' the quantitative findings have uncovered a great deal of information about risk behaviour within this specific population. In looking at a particular high risk population of casual workers, in what could be seen as one of the most hedonistic holiday resorts in the world, these figures provide a snapshot of a population from which others can be measured against.

As previously identified, one of the most worrying findings was the levels of recruitment to drug use while in the holiday resort. This has exemplified where studies have yet to measure how behaviours that are adopted may continue on return home to the UK. For that reason, in measuring recruitment to risk behaviour a longitudinal approach may be most appropriate, and will be tested in Chapter 3. Similarly, the findings showed significant links between substance use and sexual behaviour, which again is not adequately represented in previous studies and requires further exploration.

This quantitative study of casual workers in Ibiza has contributed to the aims of the thesis in providing statistical information on sexual behaviour, substance use, and the utilisation of health services in San Antonio. This forms the beginnings of an evidence base for tailored health literature and services that are contextually appropriate due to the high levels of risk measured, and low levels of access to healthcare. Yet, further information is needed to understand the reasons why such behaviours are occurring within casual worker populations in this setting; why such behaviours may be different from that of regular non –working short term tourists in package holiday resorts; and most importantly why casual workers are not utilising the healthcare services that are available in Ibiza. For that reason, the following ethnographic study will seek to provide a more comprehensive understanding of why such high levels of risk are being measured.

4.5. Ethnographic study of Ibiza casual workers

4.5.1. Introduction

Previous qualitative studies have looked at the behaviour of tourists in holiday destinations such as Bulgaria (Hesse & Tutenges 2008, Tutenges 2011), Mallorca (Andrews 2005, 2008) and Ibiza (Briggs et al., 2011a, Briggs 2013). Ethnographic fieldwork has been of significant use in identifying risk populations and particular public health concerns, such as substance use (e.g. Bourgois, 2000; Bourgois & Schonberg, 2007) and sexual health (e.g. Castro & Farmer, 2005). In terms of anthropological studies of tourists, ethnography has been applied to various populations, such as sex tourists in the Caribbean (e.g. Weichselbaumer, 2012), stag parties in Europe (e.g. Thurnell-Read, 2011, 2012) and backpackers in Australia (e.g. Brennan, 2014). Ethnographic studies have highlighted the importance of using fieldwork methods to look at populations of substance using and sexually active tourists (Briggs et al., 2011b; Sonmez et al., 2013) and casual workers (Briggs, 2013; Tutenges, 2011; Rice et al., 2010) in nightlife orientated holiday resorts.

An ethnographic study of tourists in San Antonio, Ibiza, looked at the relationships between different ‘players’ in nightlife social arenas, such as tourists, casual workers and sex workers (Briggs et al., 2011b). The study suggested that British casual workers were the group taking the highest amounts of risks in Ibiza, specifically within nightlife environments. The research only predicted the extent to which casual workers were taking part in substance use in Ibiza as both consumers and ‘players’ in the drug markets, but suggested that casual workers may be ‘key mediators’ of both sexual risk and substance use in holiday resorts. Similarly, an ethnographic study in a holiday resort in Bulgaria (Tutenges 2011) examined the way that casual working ‘guides’ (employees looking after groups of tourists) stirred up a level of ‘effervescent’ behaviour amongst tourists. Guides used tools such as speech, crowd

involvement and alcohol to mediate and encourage young tourists to take part in risky nightlife behaviours. Again, this study highlighted casual workers as a subgroup very much separated from regular short-term tourists. The term ‘effervescent’ was first coined by Durkheim (1959) in his concept of ‘collective effervescence’ whereby individuals come together to participate in the same sacred actions and thoughts, which serves to unify the group and encourage high energy levels. This term has also been used in a paper on conceptual understandings of tourism by Andrews (2009), where it is described in terms of ‘effervescent Britishness’ whereby tourists are encouraged to express their national identity whilst on holiday in a desire for familiarity.

With this in mind, it is important to distinguish casual workers from non-working short term tourists and recognise this population for having its own set of characteristics and social norms. The chapter will present the ethnographic findings from the fieldwork undertaken in San Antonio, Ibiza. The aim of the chapter is to address the research question (2) of *‘what are the everyday behavioural norms and experiences of casual workers that may affect their involvement in risk behaviours and use of health services?’* and in doing so when combined with the previous quantitative data will fulfil objective (c) of *‘Identify a high risk population of young British tourists (casual workers) in a nightlife orientated resort and use mixed methods (quantitative and ethnographic) to measure and describe their levels of risk behaviour around substance use and sexual activity and their utilisation of existing health services’*.

To support and complement the quantitative data collected in the resort of San Antonio, ethnographic fieldwork was conducted to provide a holistic view of casual workers as a particularly high substance using and sexually active population. The quantitative study of casual workers in Ibiza allowed for the collection of large amounts of data over a short period of time using short surveys; but limited the amount of description and detail that was

recorded from individuals. Further influential factors needed to be considered when building a picture of the development of risk behaviours, for example, the environment, infrastructure, peers, networks and employment patterns. Additionally, further enquiry into the levels of utilisation of health services in Ibiza was vital to inform future health initiatives. This would also allow for the development of theoretical understandings of risk identified within previous literature, and their application to specific casual worker populations. Thus, qualitative ethnographic studies were implemented alongside the surveys in 2009, and in summer 2012, to explore everyday risk behaviours of this sub population in further detail.

4.5.2. Ethnographic methods

The study adopted ethnographic research methods, using participant observation.

Throughout the initial data collection period in August 2009, observations were made of the environment that workers live in, and the everyday patterns of behaviour that take place.

Both Spradley (1980) and Fife (2005) recognise that the way in which participant observation takes place commonly happens in specific stages. Spradley (1980: 73) categorised these as;

1. *Descriptive observation, at the beginning, serves to provide the researcher with an orientation to the field under study. It provides non-specific descriptions and is used to grasp the complexity of the field as far as possible and to develop (at the same time) more concrete research questions and lines of variation.*
2. *Focused observation narrows your perspective on those processes and problems which are most essential to your research questions.*
3. *Selective observation, towards the end of the data collection, is focused on finding further evidence and examples of processes or practices, found in the second step.*

The initial fieldwork included observations and informal conversations with workers in areas that they frequented, such as beaches, bars and worker accommodation, and was written up as field notes. This initial trip could be seen as part of the ‘descriptive observation’ phase as its purpose was to provide an orientation of the research arena and the informants in Ibiza on a wider scale. Such methods provided information about worker culture, places of work, types of friendships, and places where workers socialise in their spare time. All of these factors may influence the everyday behaviour of casual workers on many different levels. A secondary ethnographic fieldwork trip took place in July 2012 over one week, and involved travelling to Ibiza with a group of researchers from the University of East London who were

compiling their own research in the area. The follow up visit aimed to enquire further into the everyday lifestyle of casual workers in Ibiza; however, it additionally included informal conversations with local residents, healthcare practitioners and local authorities. This was viewed as the more focused and selective period of participant research whereby themes and patterns were becoming more prominent and specific areas of interest identified from the initial research trip in 2009 and after the analysis of the quantitative data (Spradley, 1980). The aim of the secondary fieldwork was to build a greater picture of the local economy, areas of consumption and the harm reduction strategies that they have in place to protect young people visiting Ibiza. Additionally, the secondary research trip allowed me to re-connect with worker contacts that had been approached in the primary research trip in August 2009. Ethical approval was received from the Liverpool John Moores University Research Ethics Committee (see Appendix 2).

Recruitment and logistics

Prior to commencing each research trip online worker forums such as ‘Ibiza-Spotlight’ and ‘DigitalIbiza’ were consulted to gain background knowledge of workers’ accommodation and employment patterns. Social networking sites were also used before the secondary trip to initiate contact with casual workers encountered during the initial 2009 fieldwork study and were intending to revisit San Antonio to work in summer 2012.

Hostel accommodation was sought in a central location in the busy West End of San Antonio. The hostel was walking distance to the main ‘bar street’ and the beachfront, two of the biggest areas of employment of casual workers, with the most concentrated amount of bars and nightclubs. Each day, research took place in a number of areas of interest in San Antonio, such as the beachfront, the West End bar street area and the harbour.

Casual workers were approached and conversations were created opportunistically in public areas around San Antonio, such as the beach and the main bar street. Informal meetings were arranged with worker contacts from the 2009 research trip and took place in the bars and hotels in which they worked and within worker accommodation blocks. Recording devices were not used; all conversations and observations were recorded after each encounter or at the end of the day as field notes using a notepad and pen. This was to ease the flow and creation of spontaneous discourse and capture participants in the moment. The benefits of using field notes rather than audio-recordings is that encounters can remain natural and uninterrupted, especially if the researcher wants to remain covert. Moreover, field notes are seen as the most traditional means of data collection for ethnography, and allows the researcher not only to record what was viewed or what was said, but also to make markers that refer to the context of situations and how the researcher may have felt at that time (Hammerlsey & Atkinson, 1995). This allows for a more reflexive approach to data collection that may not be captured in audio-recording that are then transcribed away from the research setting. As an anthropologist, I felt this was the most comfortable method that allowed me to collect data using a method that I have previously practiced.

All descriptions and details of conversations were transferred from notepad onto a secure word document at the end of each day. Workers' names were not recorded at any point to protect their anonymity. When disclosing my role as a PhD researcher in conversations, consent was obtained verbally to ensure that informants were comfortable with any notes being taken.

To provide information about the health services on the island meetings were held with a local organisation, Ibiza 24/7. The organisation provides health advice and support to tourists and casual workers through a number of different services. During the trip, Ibiza 24/7 allowed me to observe their staff members to experience first-hand the services they provide

in and around San Antonio. All observational and conversational notes from the meeting and shadowing experience were recorded in a notepad at the end of each encounter.

Opinions of a variety of different individuals of different ages, gender and employment statuses were sought to enable a more accurate view of the everyday existence of casual workers. I acknowledge that there are many other dimensions that were not studied during the research trip due to time restraints, for example gender and class differences.

Analysis of findings

All field notes from the 2009 and 2012 fieldwork trips were merged and analysed manually into key themes and patterns that had emerged throughout the study (social context of San Antonio, accommodation, jobs/employment, drug dealing, drug use, alcohol use, sexual behaviour and health services). Once the themes had been manually identified, the qualitative software package Nvivo was used and nodal analysis was conducted of these themes. This allowed me to create an inventory of my fieldnotes and to clearly view the scope and coverage of the data to check that my manually generated themes were consistent. This did not impact my findings in any way, but served to strengthen my analysis and identify the most important and overarching themes.

4.6. Ethnographic findings

The following accounts of conversations and observations with casual workers, local authorities and organisations in Ibiza are taken from detailed notes recorded throughout each day of both research trips. The accounts are only representative of the persons encountered and not generalised views; information from individuals may have been exaggerated or incorrect, and is based on the subjective views and perceptions of the researcher.

* Real names of informants are not used in order to protect their anonymity therefore pseudonyms are used.

4.6.1. The social context of San Antonio

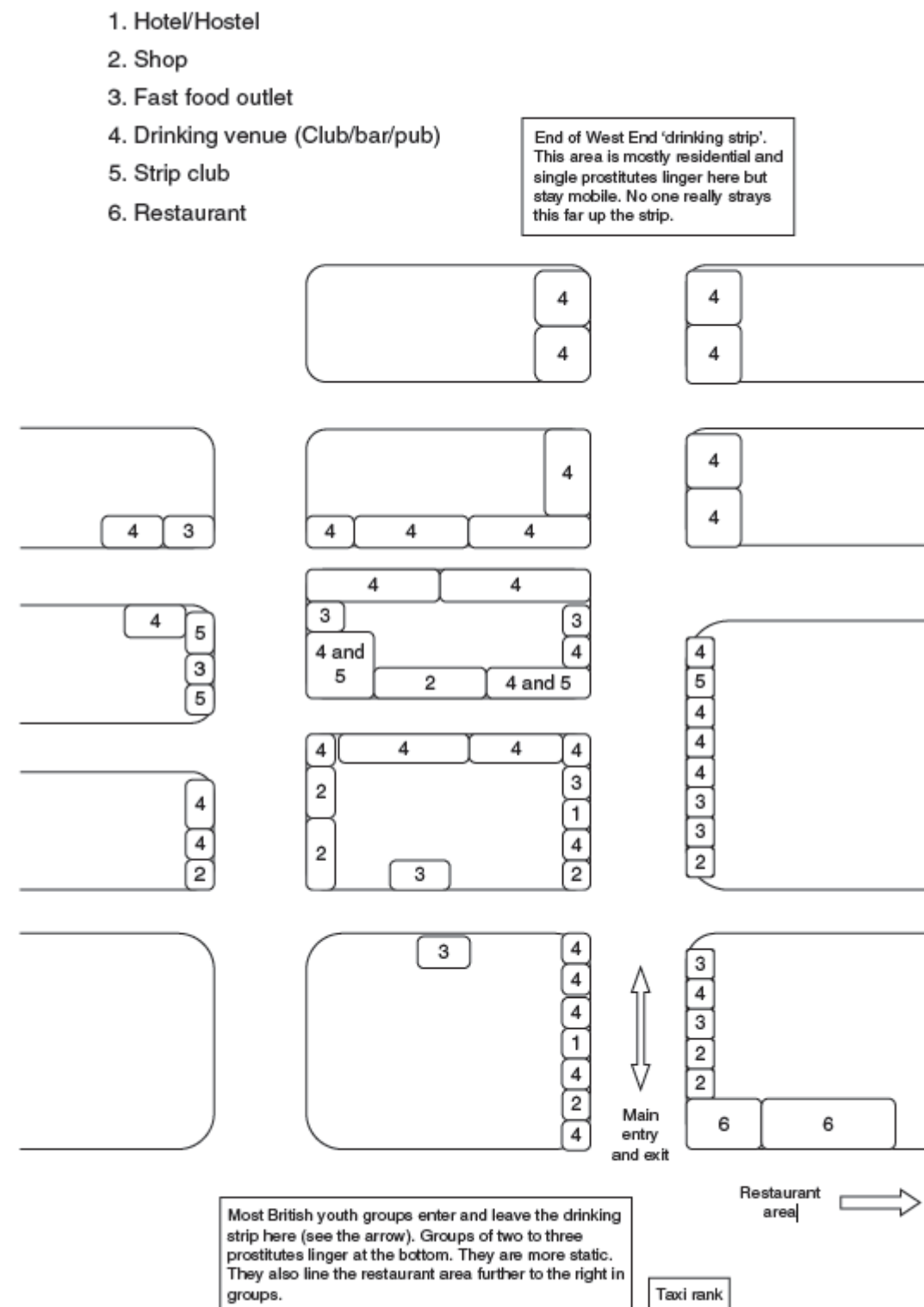
San Antonio is a resort that caters predominantly for British package holidaymakers, with most tourists and casual workers being white and working class. English is the dominant language and there are a multitude of British themed bars and cafés to cater for the tourists. San Antonio houses a number of smaller nightclubs, but the majority of the ‘Superclubs’ are based outside of the town. The resort is made up nearly entirely of high-rise hotels and apartment blocks, and many well-known global fast food restaurants on the main streets. Two of the main distinct arenas of interest for this research trip were the West End and the beachfront of San Antonio. Within these areas there was a large presence of casual workers who were involved in both the daytime and night-time economies. The West End housed a large amount of casual workers that both lived and worked in this centralised area. It is a concentrated space made up of parallel running streets with a large amount of hotels, hostels, shops, bars and restaurants. Studies have suggested that the main drinking strip in the West End of San Antonio is a place purposefully designed for the mass consumption of drugs and alcohol. It has also been noted as a highly sexualised arena with many strip clubs and the

presence of prostitutes (Briggs et al., 2011b, 2012). The West End bar strip, as expected, was a chaotic and fast-paced environment at night, with rows of bars and clubs packed into one small area (see page 101). Each night, thousands of tourists streamed up and down the drinking strip in search of cheap alcohol and loud music, and casual workers screamed out their nightly offers of ‘free shots’ and ‘buy one get one free’. The music blared all night until around 4am, with the latest house music tunes echoing down the small parallel streets.

At night, the West End area of San Antonio could be described as a large playground for both tourists and those who work in the area, with unending opportunity for debauchery and hedonistic pursuits. Yet through the day time this very same area was quiet and deserted; a complete juxtaposition to the night-time activities. Each morning there was the same view of chip wrappers and empty beer bottles strewn across the street, and hungover tourists making their way back to hotels, clasp to each other for strength.

The beachfront area of San Antonio was quieter and more dispersed than the West End and home to many well-known bars that are linked to the main ‘Super-clubs’ (e.g. Pacha, Privilege, and Amnesia). DJs played throughout the day and night and hosted pre-club warm up parties, so the bars were popular with club goers and dance music enthusiasts from morning until night. These bars screamed ‘exclusivity’ and housed only well-dressed patrons sipping cocktails whilst overlooking the bay. The area had a carnival like atmosphere with ‘house’ music played on loop and dancers performing along the promenade, much like the ‘Balearic beat’ previously described. The beachfront in particular had a large amount of ticket sellers who approached customers both on the beach and along the promenade. There was literally no escape in this area from young casual workers shouting out their best nightclub ticket deals, and the ever present African and Eastern European drug dealers, selling sunglasses and bracelets as a decoy for their illegal activity. Focusing my research on the beachfront allowed me to approach workers in a less chaotic environment than the West End,

and enabled many conversations and observations to take place during the day in this beachfront location.



Map of the West End 'drinking strip' as visualised by Briggs, 2013:4

4.6.2. Accommodation

Casual worker accommodation that was observed in San Antonio was varied, from private apartments, hotel rooms and hostels. Many workers I spoke to had arranged accommodation in shared apartments before arriving on the island, typically through adverts placed in online worker accommodation forums. Some had tried to group together to secure apartments with friends, yet a lack of accommodation meant that this was often difficult. Some began their stay in a hotel or hostel and then sought permanent accommodation once they had found a steady job. It was said that very few locals inhabited San Antonio as the scenery is dominated by large hotels and apartment blocks designed for tourists, reminiscent of other Spanish party resorts like Benidorm or Magaluf.

For locals, renting apartments to young British workers was seen as one of the biggest money making industries in the area. An estate agent in the centre of the West End operated a casual worker accommodation service, whereby workers were put on a waiting list for beds to become available. Private apartment blocks, particularly in the West End area, housed around six to ten workers in one apartment, with apartment rates charged by the bed or sofa, rather than by the room, with multiple people sharing one small space. Apartments were very communal with privacy at a minimum. Information from locals told me that landlords were known to fill every room with extra beds and sofas to make a bigger profit, making conditions cramped. The estate agents confirmed that workers typically paid between 150-300 euros a month (approx. £125-250) for a bed or sofa. Workers came and went throughout the season, and their beds were instantly filled by landlords with new arrivals. However, a shortage of apartments and beds meant that many workers I spoke to sought long-term accommodation in hotels and hostels. Consequently, this proved costly for workers on a low income or unemployed, leading to cases of homelessness and vulnerability. Such workers relied on squatting in other people's apartments or even sleeping rough outdoors until they

could source enough money to find a home. It is important to note that although there was a great deal of 'workers' in San Antonio, not all of them were in employment at the time I encountered them. Yet their intentions to stay for a longer period of time than regular tourists and the fact that they might at some point actively seek employment made them a 'worker' in the eyes of the 'worker' population. For the purpose of this study I followed these cultural rules and started most of the conversations by asking the individual if they were a 'worker'; and if they answered 'yes' I described them as such, even if unemployed.

Choice of accommodation appeared not to be a priority for workers, as the emphasis lay on simply surviving in Ibiza for as long as possible, no matter the conditions. This was especially true for first time workers I came across who were keen to take part in the full Ibiza experience, no matter where they were sleeping. For some, accommodation was only used as a place to store belongings as workers had little time off work and spent most of their free time sunbathing and partying. In some accommodation blocks I was informed that there were parties that went on all day and night, in which case workers had no choice but join in or find somewhere else to sleep.

I came across two young male British workers who were homeless and had little money. They had been in Ibiza a few months and had spent thousands of euros on excessive partying. Both carried small plastic bags holding their belongings and were planning to sleep on the beach that night. They looked dishevelled and dirty. They had previously been earning around 25 euros a night between them; however the cheapest local hostel was 20 euros a night, leaving them little money for food and water. Yet they were still reasonably cheery and upbeat.

The males had no intention of going home and 'giving up'. The pair only had enough money to put their first month's rent payment down on a bed or sofa, and were waiting for a place to become available from the local estate agent service. The males were unfazed by potentially being placed in a random apartment with workers they had never met. They were more concerned with finding somewhere with a kitchen as they could not afford to eat out.

(Field notes, 2012)

Seasoned and older workers I encountered seemed to place greater importance on securing accommodation with their friends, which required advanced planning before arrival on the island. They spent their time building contacts with landlords to secure spacious accommodation in more attractive and quieter areas of the resort. Sometimes this required a large deposit to be paid before the summer season commenced and regular contact to be kept with the prospective landlord. Seasoned workers placed less importance on visiting nightclubs and bars and were more likely to relax and socialise in their apartments, therefore placing a higher premium on comfort.

I visited an apartment block in a quieter and more attractive area of San Antonio to observe its inhabitants. I entered an apartment on the top floor that was surprisingly large and spacious, set out like a tourist holiday home, with an impressive décor of columns and archways. The main entrance room led onto a terrace balcony filled with flowers and patio furniture. The apartment was shared between eight people, all of whom had their own beds; however, the beds were more like military style camp beds laid out across what was once a

living room floor. All the inhabitants were seasoned workers who had met working previous summers in Ibiza, two of whom were sisters who shared the only double bed in the apartment. The apartment had been originally secured by Karen* (who had worked five previous seasons), who had invited friends to live with her. The housemates spoke of how lucky they felt to share a nice apartment with friends as many had previous bad experiences of sharing with strangers. Some had lived in cramped conditions where their belongings had been stolen or lived with people they considered rude and ill mannered. Subsequently, the girls had concerns that one of them may lose their job and be forced to return to the UK, leaving an empty bed to be filled with a stranger by the landlord, ruining their 'beautiful home'.

4.6.3. Jobs and employment

The West End area employed mainly PRs (promotional representatives who hand out flyers) and bar/waiting staff. Workers in this area were required to operate in a fast paced and chaotic environment which was felt to be very high pressured. The PRs offered cheap alcohol and bars played loud music, appealing to boisterous young British holidaymakers. Everyone was scantily clad with females dressed in tiny shorts and cropped tops, and males wearing sleeveless t-shirts revealing a multitude of tattoos; it was almost like a uniform. Drunken tourists staggered up and down the streets, with groups holding hands so as not to lose their friends in the chaos of swaying drunken tourists, loud music and PRs shouting their offers above the pounding beats. Walking down the West End drinking strip every night you could potentially be approached by up to 20 PRs in the space of 100 metres, all competing with each for customers. Some workers were even physically grabbing tourists and carrying them into their bars. The area felt overwhelming, and as a sober researcher dressed in my normal

everyday plain clothes, I was very aware of my place as an ‘outsider’ in this space as I was not drunkenly staggering about, singing to the music or reacting to PR staff from the bars. Yet, those around me seemed oblivious to my presence, so in some part I must have blended in, or they were too intoxicated to notice me.

The beachfront area in comparison was viewed by workers as more of a desirable area to work as it was slightly quieter and the bars were more exclusive and ‘classy’, attracting a more varied clientele. When walking down the beachfront it was clear that the PRs were a lot less pushy, however the presence of ticket sellers (with their sleeveless t-shirts and tattoos) made for an uncomfortable walk as they were clearly all competing with each other for sales. Yet the very fact that I was being approached made me feel as though perhaps my image was that of a regular tourist, and I was not actually out of place.

Most workers I spoke to told me that employers had requested CVs with an attached photograph. Bar owners were felt to seek out the most attractive, confident and reliable workers as they had limited time to utilise staff and make their money. Online workers forums, such as ‘DigitalIbiza’, operate all year round advertising jobs on the island. For those who arrived without jobs there were a number of ‘worker bars’ which had noticeboards advertising available work, yet the choices were slim. When sitting in a bar having a cold drink it was not uncommon to see individuals walking in with CVs and walking out disappointed. It was obvious that the competition for jobs was fierce, not surprisingly with a mass influx of young British people descending on the island every summer, and clearly not enough jobs to go round.

Many informants had worked in Ibiza numerous times before, yet had only secured ‘decent’ jobs during the 2012 season. Some had come over as early as April to get the best jobs, however it was felt that most of the employers firstly only took on those with previous

experience of working in San Antonio. This meant that many first time workers could not find employment until June when the season started to get busier.

I sat by the pool with Lisa, a young Scottish worker, was employed in the Ibiza Rocks hotel as a pool bar waitress. She told me that the Ibiza Rocks Hotel was one of the most desirable job locations on the whole island. All of her friends were jealous that she had landed such a good job. She had worked five seasons at the same hotel, spending every summer on the island from April until October. Her workplace received thousands of applications for jobs every summer with competition extremely fierce. She estimated that there were around 3,000 workers in Ibiza, 2,000 of whom were in and out of work or unemployed. Lisa felt very lucky to be in such a rare position. She had earned her position by remaining loyal to the same employer each year and building a good working relationship with her managers.*

(Field notes, 2012)

The first time workers that I came across treated San Antonio like a playground, getting caught up in the novelty of being on an extended holiday, attending parties and events and going to see the best DJs. Many had got involved in excessive drinking and drug use early on in the season, and had lost jobs due to lateness or turning up to work inebriated.

Chelsea (a first time worker) told me she had been visiting apartment parties most nights and took loads of drugs; typically large amounts of ketamine, ecstasy and MDMA. There was always a guaranteed supply of*

cheap or free drugs at any time of the day or night from her friends, which worked well for her. Sometimes she didn't bother to show up for work as the parties would go on or days.

(Field notes, 2009)

Consequently, first time workers were renowned for spending all of their money in the first few weeks, leaving them little to last the remainder of the season. Many spoke of individuals that had arrived assuming that employment opportunities on the island would be limitless and that they would be able to find work at any point in the season. Yet stories were told of those who had struggled to find work, eventually admitting defeat and heading back home after only a short period of time.

Employers that I spoke to always emphasised their reliance on trust and loyalty from staff, and that they didn't take risks on employing staff who may be naïve to the industry or caught up in the novelty of partying. Bar and nightclub owners appeared to have a love/ hate relationship with young British workers. At night on the West End drinking strip you could commonly see bar managers shouting at their staff in frustration for not bringing in enough customers or being too drunk. A British couple who owned a local fish and chip shop in San Antonio had previously owned a bar employing young British workers in the West End. They eventually sold the bar due to the problems they faced with unreliable staff that repeatedly did not show up for work. They felt that casual workers were disrespectful, were not willing to work long hours and just wanted to get drunk. The couple only had the summer to make their money and felt frustrated by the attitude of this population of temporary employees who were not willing to work hard and help them out.

Ashleigh served my dinner and I initiated a conversation, she was a first time worker who had worked in the restaurant for just under a week and had been promised 1500 euros a month (approx. £1250) for working eight hours a day (5pm until 1am), seven days a week. She felt incredibly lucky to have a 'secure' job with a good wage, having worked trials in bars in the West End without pay. She felt she didn't stand a chance getting a good job as this was her first season. Ashleigh was often required to flirt with groups of drunken males, many of whom threw insults and rudely beckoned her while she worked. As we were talking a group of males on the next table were clicking their fingers to get her attention. She always responded jovially to them, often flirting with them to 'keep them drinking'. She was in charge of over ten tables at a time and was expected to PR to passers-by, a hard task in such a busy environment. She told me that one night a large group of British males left without paying so the 80 euro bill came straight out of her wage.....After a few nights I revisited Ashleigh who felt less expectant of receiving a full wage due to the amount of walk outs from her tables. She was fearful of losing her job and struggling to keep up with the demands of her boss, however her general opinion was 'it could be worse'*

(Field notes, 2012)

Employers in San Antonio were required by law to supply work permits to their employees, at the time costing around 1500 euros per person (approx. £1250). Local authority officers dressed in casual clothes were said to operate undercover in and around San Antonio

checking the work permits of individuals at random. If staff were caught without work permits, the bar/nightclub/restaurant owner could be fined around 1500 euros. Many workers were wearing waistcoats provided by the local authorities with the name of their employer printed on the back, and were carrying their work permit around with them during working hours. However, to avoid paying for work permits I was informed that employers commonly only gave waistcoats to the most visible workers who are most at risk of being caught. The remaining less visible staff members were simply told to sit down and pretend to be customers if they spotted any 'official looking people' coming their way. This made me aware of my own appearance as a casually dressed researcher walking around the area on my own and making notes, which may have looked pretty suspicious. This was apparently typical practice amongst employers in the area due to the high turnover of staff. This exemplified the pressure that bar owners were under to make their money over the summer, and the existing tensions within the local economy.

One of the most common and noticeable types of work available in San Antonio was ticket selling. When walking up and down the promenade I would be approached by a young ticket seller, and five minutes later I would walking back and the same ticket seller would re-approach me having not remembered our previous encounter. It was clear that nightclubs (in particular the Superclubs) on the island were saturating the resort with hundreds of ticket sellers, all mainly operating on commission (approximately ten euros per ticket sold- £8.50). Nonetheless, ticket sellers I came across found it difficult to make an income as lots of ticket sellers usually covered one small area, often from the same nightclub and selling the same thing.

I approached two young females working at a 'bunjee sling shot' ride on the beachfront and they told me that although they currently hated their job and were only paid five euros an hour, they had previously only earned 20 euros a week between them selling tickets for a large nightclub. They believed that unless a ticket seller can 'talk the talk' and put in long hour shifts they would ultimately be unsuccessful in this line of work as it is far too competitive. At that point their manager called them away from me.

(Field notes, 2012)

I was told that ticket sellers were more desirable to employ and made more money if they could speak a number of languages in order to sell tickets to customers of different nationalities. You could see that ticket sellers operated in 'patches', which caused confrontations between sellers. I noticed that tickets and wristbands that were sold were usually initialled and dated so that the clubs knew how many each staff member was selling each day. It became clear to me throughout the fieldwork that unless workers were ruthless, determined and desperate it was impossible to last in such a competitive market. A small proportion of sellers were lucky enough to sell tickets for events that are guaranteed to sell out.

Matt worked on the beachfront for a popular boat party cruise called 'Pukka Up'. He told me that his experience so far had been positive as he felt he was good at his job. He felt that all of the bad ticket sellers tend to be filtered out throughout the season, however as he was 'decent' there was a lot of money to be made. He also worked for the 'Pukka Up' bar (linked to the boat cruise) earning 35 euros a night basic wage alongside*

the 100 euros a day he made selling tickets for the boat cruise. The boat cruise was the most popular on the island with tickets selling out every day. The company only employed a small number of ticket sellers due to the high demand so sales were always guaranteed. He had it easy.

(Field notes, 2009)

The determination of casual workers to stay in Ibiza was notable, with poor work conditions and low pay not acting as deterrents in any way. Yet it was felt to be ‘worth it’ to be classed as an ‘Ibiza worker’, even throughout periods of unemployment. Young people were working extremely long hours with the constant threat of job loss, with casual workers becoming an increasingly disposable workforce.

4.6.4. Drug dealing

Due to the lack of jobs available in Ibiza, low income and the determination of workers to stay on the island for as long as possible, some workers that I spoke to were considering turning to drug dealing. Equally, many were already involved in drug dealing and were living quite precariously. Young British workers were also getting into debt due to the excessive Ibiza lifestyle and cost of living, with pressures leading them to seek a source of income through criminal means.

A previous study of young people in Ibiza had briefly suggested an existing level of involvement in drug dealing by casual workers in San Antonio (Briggs et al., 2011b). During my time in Ibiza I suspected that there was a large drug market fuelled by young British workers, yet I was only able to touch the surface of this issue, due to the dangerous and

sensitive nature of drug dealing. As a researcher, it was often difficult to engage with workers who were involved in drug dealing activity, due to my own moral views, and the criminal aspect of this behaviour. Yet within this arena it was a subject near impossible to avoid as it was so engrained into the everyday behaviour of workers, therefore could not be ignored. The following excerpts from the research trip describe, in as much detail as my research permits, the drug dealing activities that take place on a daily in San Antonio.

Demand for jobs and low wages meant that some workers were left unable to pay their rent or afford to fly home and were getting themselves into serious trouble. Many I spoke to had turned to drug dealing as a quick way to solve their financial problems and keep them on the island for longer. Although this was a last resort for some, others actively chose to supplement their wage by selling drugs or to sell drugs as a full time job. Drug dealing was a notoriously quick way to earn cash and status within this population, so an attractive option for many. In particular it was felt that many first time workers were getting involved in selling drugs as a way to look 'cool' and fit in with more established workers on the island. Individual workers I spoke to felt that they were being targeted and often coerced by gangs into selling drugs on the island, but that this was not a new phenomenon. Large scale drug suppliers and networks of dealers were apparently targeting young British casual workers and recruiting them to smaller scale dealing on the streets of San Antonio. British workers were seen as a prime choice to deal drugs due to their everyday encounters with tourists and other workers. This was not surprising due to their mass presence on the streets at all hours of the day. Local police officers informed me that gangs had been known to take passports from young British workers to secure their involvement in dealing and make sure they did not leave the island. The involvement of young British workers in drug dealing had made the networks larger, therefore harder to trace the chain of supply. Of course, I cannot make generalisations about the extent to which this was actually occurring, or the truth in the

conversations that took place; yet these encounters were common, and the openness of workers to talk about drug dealing seemed to be almost inherent to the culture itself.

I met Ben, a boat party ticket seller working on the beachfront, he talked relentlessly about his drug dealing career in Ibiza. He sold cocaine for 60 euros a gram, ketamine for 35 euros a gram and pills at ten euro each. Ben was selling drugs alongside tickets for the boat party to supplement his income and survive longer on the island. Selling drugs was easy as he was constantly being approached by customers wanting tickets. For a group of ten males he would make ten euros a ticket, plus 200 euros from the pills he would sell to them; totalling around 300 euros in the space of half an hour. He believed that even if you have a poorly paid job in Ibiza you will always be able to stay afloat by choosing to deal drugs. He loved this job and never mentioned the criminal consequences, almost like they were not on his radar.*

(Field notes, 2012)

One of the most common stories I heard from informants was of a place known as ‘Ket Castle’; an apartment block by the beachfront of San Antonio. I chose not to enter this block for my own personal safety, especially as residents appeared visually intoxicated, although I learnt a great deal about this particular residence from workers that frequented it. Workers living in the block were mostly full time drug dealers selling mainly ketamine from their apartments. Ket Castle hosted numerous all night parties for workers throughout the summer season, particularly for ketamine users, that were known to continue for days at a time. I

stood outside of Ket Castle one afternoon and stared up at the imposing building; it looked quite modern with its white washed walls and glass balconies. However it was clear I was at the right location as you could visibly see parties occurring with workers dancing and drinking on the balconies and loud music coming from different apartments. It surprised me how visible the disorder was, and how dishevelled the inhabitants looked. Drugs were known to be in constant supply from resident dealers, who stayed in the block. It had been predicted by workers that Ket Castle would soon be raided as it was becoming well known that people were both living and dealing from the apartments. Nevertheless, I would predict that other similar blocks were in existence in other areas of the resort that would soon replace it.

Whilst chatting to a group of workers on the bar strip, two male workers approach Coral, a young female PR in the group. They ask if she is going to Ket Castle later as they have some 'gear' for her, Coral makes plans to visit after work and continues to openly discuss buying drugs in front of me. This is becoming more common.*

(Field notes, 2012)

Throughout the research trip I was offered substances on numerous occasions from a variety of different sellers. I had noticed that tourists were often pointed in the direction of British workers if they wanted to buy drugs. Visible street sellers from Africa and Eastern Europe regularly approached tourists selling drugs amongst their other wares on the beaches, on the street and in many bars. However, I was informed that the street sellers in the area were known to cut their drugs with such substances as talc and painkillers.

For this reason, workers were typically only purchasing their drugs from friends. Although they could get cheaper drugs from street dealers, they were not willing to risk wasting their

money on poor quality substances. Workers I spoke to kept each other informed about new or dodgy substances that had entered the area, and gave each other advice about where to purchase 'decent' drugs. It was quite a rarity in this population to find groups that did not take drugs; for that reason purchasing drugs from fellow workers was seen as a way of self-regulating the industry and protecting themselves from harm.

Kelly lived in the West End and purchased drugs from workers that lived close by. She preferred using pills called 'pink rockstars' as they were good value and had the best effects. She knew little about the ingredients of the pills, but suspected that they were mostly ecstasy based with a bit of amphetamine mixed in. She told me this without concern. Kelly had a dealer, who was a British club promoter and delivered drugs to her apartment on a weekly basis depending on what club events her and her roommates were attending. He would pull up in a car outside and she would run downstairs to collect. Kelly was cautious as some pills distributed in the area had been fake. She said you could rub the pills between your fingers to see if the pink dye transferred as a way of testing the authenticity of the pills. As pink rockstars were very popular amongst workers, street dealers had started dying their pills pink. Her friends had recently been sold what they thought was MDMA from a street seller which had turned out to be what she thought was crushed paracetamol. I wish I had asked how they came to this conclusion.*

(Field notes, 2009)

Although casual workers were involved in the selling of drugs, they all seemed keen to keep this at a low level in terms of interacting with higher level networks. Much of the drug industry seemed to be built around a culture of fear and the involvement of gangs, and therefore as far as casual workers were concerned the fewer questions asked, the better. It was felt that the local police were surprisingly lenient on drug dealing in the area, and workers spoke of friends that had been caught with large amounts of drugs and only given a caution or had their 'stash' (drugs on their person) confiscated. This meant there were few deterrents to dealing drugs and little fear of carrying drugs or storing them in apartments.

I sat with Adam on the beach, he told me that he had many drug dealing friends in San Antonio, one of which supplied him with the drugs that he sold; therefore they split all profits. They never discussed where the drugs came from or talked about the chain of supply, they were happy to 'keep their mouths shut' for fear of jeopardising their small business. He spent most of his time in 'Ket Castle', visiting there after work and stay up all night taking a variety of substances. Adam and his friends liked to take ketamine during the day and walk round the beach and pools as it felt like they were 'floating'. They had a constant supply of drugs between them so used regularly during their time off work. I was worried that he might invite me to join them so left shortly after.*

(Field notes, 2012)

When it came to talking about drug dealing, workers became quite animated and enthused at sharing their experiences. When chatting to workers in bar areas it wasn't uncommon for

them to stand up excitedly and narrate a story that they had been heard about drug dealing in the area. Some told stories of drugs being shipped into Ibiza Docks on a daily basis. Due to supposed ‘corruption’ by the Ibiza Police and dock workers the drugs were believed to be allowed to freely pass through. Some knew of friends who went to Ibiza Town on a regular basis to ‘collect’ large packages of substances. Ultimately, workers had been led to believe that corruption within local authorities meant that police services were profiting from drug dealing on the island, not that they were particularly concerned by this. The criminal justice system was viewed as ineffective and corrupt; therefore, it was perceived that drug networks were freely allowed to flourish without the authorities intervening. On the other hand, it could be surmised that the drug industry had become a normalised part of the Ibiza economy, so much so that young British workers were being desensitised to its criminality. Yet, without studying local authorities, such as the police, in any detail it is difficult to confirm what the official line is on drug taking and dealing activities on the island. I can only reflect on what was captured in my field notes and observations that led me to believe that workers had no apparent fear of talking about drug use and drug dealing. It seemed to be such an inherent part of their everyday existence that the criminal aspect of such behaviour was barely even comprehended.

4.6.5. Drug use

Throughout the fieldwork it became apparent that substances were very easily accessible and widely offered across San Antonio from a variety of sources such as street sellers, casual workers, prostitutes, bar owners, bouncers and tourists. Drugs were consumed, sometimes openly in front of me, in bars, nightclubs, on the beach and even in restaurants. On one occasion a professional looking man in his 40s proceeded to snort lines of cocaine off his

table over lunch in a beachfront eatery, and nobody appeared to stop him or discourage his behaviour. This was one example of what happened on a daily occurrence during my fieldwork trips. It seemed like drug use formed a large part of the Ibiza economy, so much so that nightclubs were said to charge larger entrance fees and increased drinks prices due to the fact that so many of their patrons use drugs rather than buy alcohol from the bar.

Exposure to drug use appeared near impossible to avoid within this culture of hedonism and experimentation. One informant (casual worker) estimated that 95% of British workers in Ibiza take drugs, and if they claimed they did not they were 'clearly lying'. To those unfamiliar with drug use, San Antonio was said to provide a vast education, not just for myself, but for other workers, with many first time visitors choosing to 'drop their first pill' (i.e. use ecstasy for the first time) on the island. Losing your 'pill virginity' was seen as a common practice for first time workers in San Antonio, often with the assistance and encouragement of seasoned workers.

Ibiza was considered to be a 'hard-core' place to work, with young people working long shifts and partying until the early hours. Recreational drug use was seen by many casual workers as an aid to balancing this work/party lifestyle, catering for those who need to work hard to fund their hedonistic nightlife activities. The actual use of drugs by casual workers seemed reasonably covert due to its illegal nature; however, it was clear that many workers in the resort were showing symptoms of use, such as dilated pupils and erratic conversation style.

Laura appeared incredibly thin and spaced out, but somehow no different from the workers sat around her, perhaps she was the worst. She informed me that she took a lot of drugs on a daily basis, mainly ketamine, and attended*

nightclubs around three times a week. The rest of the evenings she would spend at Ket Castle with her friends. On a typical night she would take three pills but was growing very tolerant of them so sometimes took more. She ate rarely as the drugs suppressed her appetite and she slept for only three hours every couple of days. Sleeping made her feel worse, so she continued to stay awake and use drugs regularly to repress these feelings. When the drugs wore off and she felt hungover, she simply took more substances to delay the effects. During this conversation it was hard not to express my concerns and offer advice, I was genuinely worried.

(Field notes, 2012)

One group of bar workers from the West End drinking strip told me that ketamine was the most popular drug of choice for workers in San Antonio due to its price and potency. The workers were a mixture of males and females all aged around 25 years, who all worked in the same 'Scottish themed' bar/pub. They were sat outside of the bar in the afternoon to get out of the heat of the sun and to have a few beers. The conversation quickly turned to drug use and they told me that workers generally took a lot of ecstasy over each season, however growing tolerance to the drug meant its effects quickly lessened resulting in increased consumption each time. However, ketamine was offering the same effect with every dose, making a cheaper and more effective way to frequently use. The bar workers could not afford to attend nightclubs due to the high entrance fees, so chose to socialise at 'Ket Castle' throughout the week or attend apartment parties in and around San Antonio. This was seen as an effective way to make friends and socialise with workers without the presence of tourists.

As the research developed, it became clearer that drug use formed an important part of the social structure of San Antonio, and was so engrained into their culture that it was frequently brought up in conversation without any prompt. Ket Castle was a main talking point, and perhaps something representative of a magical and symbolic location whereby anything could happen. Drugs were frequently being used to facilitate and heighten social encounters and form transactional relationships, in such a way that to *not* take drugs may actually leave a person ostracised in this environment.

4.6.6. Alcohol use

The bars in San Antonio heavily promoted cheap drink offers to tourists encouraging excessive alcohol consumption. Bars were offering ‘2 for 1’ drinks deals and ‘free shots’ with every round of drinks ordered on a nightly basis. Spirits were free poured and typically equalled a UK double or treble measure (two or three units of alcohol, with a UK unit being 8mg of pure alcohol). A local health worker told me that this unregulated consumption of alcohol meant that the strength of drinks were often underestimated, leading to unpredictable levels of intoxication. Spirits were mixed with sugary caffeinated concoctions, such as ‘vodka red bull’ (one of the cheapest drinks available in most bars). Walking down the West End bar street area of San Antonio it was not uncommon to see tourists vomiting on the street, unable to walk or passed out unconscious down side streets.

When walking down the Wet End bar strip at night it was apparent that workers were under the influence of alcohol, swaying from side to side and dancing in a drunken fashion. For these bar workers, drinks were regularly free of charge and typically served in plastic cups so that staff could drink on the move. Many PR workers held a drink in their hand, such as a pint of blue coloured cocktail, whilst trying to sway tourists into their bar.

Kate, a waitress in a busy sports themed bar, was running tables both inside and out whilst dancing along to the loud music. She told me that she was allowed to drink during her shift as the boss preferred the staff to be energetic and confident, although there was a limit so that they did not get too drunk. On some nights of the week the boss lined up shots for the staff but only if he is in 'a good mood'. Kate always tried to get as drunk as possible whilst working as it was too expensive to drink in other bars and clubs after work.*

(Field notes, 2009)

Outside of working hours workers were able to access cheap alcohol from off licenses and supermarkets. Some workers attended a lot of house/apartment parties after work to save money, whilst others relied on making friends with bar and nightclub staff in order to get discounted drinks. I chatted to a young female ticket seller on the beach and she told me that this was the only way she planned to survive a season without spending all of her money, even if the friends she made were fake or 'fair weather'. Local bars, restaurants and clubs (mainly in the West End bar street area) had recently grouped together to offer discount on drinks to workers using a wristband system, however it was unclear if this had been successful. This was seen as a way for local businesses to make money out of workers, whilst simultaneously stopping their own staff from giving away free drinks to their friends. There were also a number of worker-orientated bars in San Antonio, the most popular of which was called 'Viva' at the top of the main drinking strip. Many workers parties and events were held every year in Viva throughout the summer seasons, offering further discounts and drink offers to those employed in the area. Stories told of parties that had lasted for days at a time, where workers would dress up in costumes and take over the area, running around the streets,

and ‘reclaiming their land’ from the hordes of tourists. This meant that the biggest presence on the streets was mainly of casual workers, rather than tourists, but only for this short time.

The large ‘Superclubs’ on the island, such as Pacha and Amnesia, charged around 50 euros entry fee (approx. £42). Drinks were around five euros (approx. £4.25) for a small bottle of water and around ten euros for a beer (approx. £8.50), with no drink offers available, which made for an expensive nightlife arena even for tourists. For that reason, many workers planning to attend nightclubs chose to preload in their apartments before going to nightclubs, often stocking up on cheap alcohol from local off licenses.

I spoke to Ben who was standing on the promenade selling tickets for a boat tour. He was a host who worked on the boat during the day and was expected to drink and party alongside the tourists to help create a lively atmosphere. He was then required to return to the bar he worked at in the evening to drink with and accompany groups of tourists to the Superclubs. He worked long hours so did not like to get too ‘wasted’; nevertheless, his boss had a habit of trying to get his staff intoxicated at the end of each evening ‘for a laugh’. He had plied Ben with shots of absinthe (around 70% proof alcohol) earlier in the week to the point that he was unable to walk. Ben was not concerned about his daily alcohol use as he always had a good time and felt lucky to have such a generous boss.*

(Field notes, 2012)

I was told by many that employment commitments may have potentially had an influence of the levels of alcohol that some consumed, as many workers did not want to risk a hangover in

fear of losing their job. This was particularly true for hotel workers that I came across that worked early mornings and ticket sellers who worked long days in the heat. One worker who worked in a popular hotel had given herself rules for her drinking behaviour; including being home in bed for 2am at the latest and drinking only water for the last hour she was out in a bar or nightclub. This enabled her to get up at 8am every morning to go to work. In observing patterns of alcohol use in San Antonio I can see how drug use could be a more popular option due to its cheaper price. Similarly, many believed that drugs were a more sociable choice for those wanting to make friends with other workers as it allowed them to remain in control, rather than be drunk and incoherent. Nevertheless, for many drinking was an actual part of their job, therefore excessive use could be seen as reasonably unavoidable.

4.6.7. Sexual behaviour

Throughout the research trip I attempted to approach workers to talk about their experiences of relationships and sex during their time in San Antonio. I aimed to avoid any specifically uncomfortable topics of conversation unless instigated by the informants themselves. Sexual behaviour was a hard topic to broach due to its private and sensitive nature. Understandably, workers were not willing to share information on the number of people they had slept with or whether they had faced any health concerns involving their sexual behaviour. In trying to conform to their cultural understandings, as a researcher I could only respect this. The following excerpts are from brief conversations with the workers and local authorities on general sexual behaviour in the resort.

I talked to a group of female workers on the beach who had chosen a day where they were not hungover from the night before to top up their tans and catch up on gossip with their friends. They began to speak about their sexual exploits from their season so far, proclaiming

repeatedly that that they preferred to have sex with other workers where possible. Many had tried to form temporary relationships over the season so that they were not ‘sleeping around’ or getting a bad reputation. The females were wary of being tarnished as sexually promiscuous and felt that they did not want to take part in one-night stands with tourists that were not meaningful. The relationships with other workers that were described were mainly friendships involving sex, not necessarily requiring monogamy, and build upon a mutual understanding. They claimed that most first time workers tended to sleep around as a result of being drunk and naive. However, when speaking to first time workers they stated that they simply felt the need to let loose and be sexually uninhibited whilst away from the constraints of home; quoting ‘what happens in Ibiza, stays in Ibiza’. Seasoned workers in comparison seemed more likely to try and form a steady relationship over the season with less interest in sex with multiple partners. Nevertheless, they claimed that in general sexual promiscuity and casual relationships were far less frowned upon (and sometimes encouraged) within the worker community.

I met Coral (a strip club PR) who felt that the spread of sexually transmitted diseases like Chlamydia and Herpes was ‘rife’ in San Antonio. She described workers as ‘incestuous’ and said that groups of workers that hang around together usually end up sleeping together at some point during the season. Many of Coral’s male friends did not use protection yet continued to sleep with both workers and tourists. She predicted that many of them would be going back to the UK with a ‘dose’ (an STD)*

(Field notes, 2009)

Many workers told me that the jobs in San Antonio often required staff to be open to sexual promiscuity, and staff could be expected to dress in a particularly provocative manner (e.g. short skirts, low cut tops, tight t-shirts); in particular young females. This seemed particularly true of PR staff I encountered in the West End, and dancers that worked for the strip clubs. Staff were also expected to flirt with tourists to keep them drinking and spending money within establishments. An example of which was Ashleigh*, mentioned earlier in the chapter, who was expected to flirt with groups of males, even when they were using derogatory language towards her. This led me to think that this could potentially lead to increased sexual encounters and short-term relationships between workers and tourists. Consequently, workers could potentially be changing sexual partners on a nightly or weekly basis, increasing the chances of STDs spread between populations, with some, such as Chlamydia, having no symptoms and therefore potentially lying dormant in workers for the entire summer season. However, without further enquiry I was unable to state this as fact.

There was an evident population of workers that were employed in local strip clubs in the West End bar street area of San Antonio. There also appeared to be a large presence of prostitutes of many different nationalities working in the area, seemingly catering mainly for young British male tourists. However due to ethical and safety considerations I was unable to study this in further detail.

Beth and her friend were working selling tickets for a small nightclub in San Antonio, they weren't making much money and were thinking of going home to the UK. They looked pretty drained and like they were ready to give up. They were both trained dancers and had arrived on the island believing that they would be able to get jobs*

dancing in the large Superclubs. They had since found out that dancing jobs were all taken early on in the season and they were too late. They said that loads of girls who arrived to dance in nightclubs were now dancing in strip clubs in the West End instead to make money. Beth and her friend were not willing to do this and felt that it was dirty and sleazy. I wondered how many more women this had happened to.

(Field notes, 2012)

Local healthcare workers informed me that genitourinary medicine services were only available over winter for Spanish residents. There were no current services operating over the summer season that were accessible to British tourists and workers. The only place that workers could visit was the Can Misses Hospital in Ibiza Town, where they were able to be seen by a general practitioner or nurse. However, there were no leaflets or information available that would point a person in that direction. Most workers I chatted to about sexual activity when asked about their needs felt that a local genitourinary medicine clinic type service offering free condoms and STD testing would be greatly beneficial to their small but very sexually active population in San Antonio. Nevertheless, many claimed that they would rather wait until they got back to the UK to be tested due to a lack of trust in foreign health services, and fear of additional costs (to be discussed further on).

Understanding the sexual behaviours of casual workers was a hard task, something that may benefit further from more anonymous quantitative surveys or one on one interviews. During my research I was unable to study in detail the link between drug and alcohol use and sexual behaviour, something that had been highlighted in my quantitative findings. I did however

get a picture of the lack of sexual health services available in the resort for both tourists and casual workers. It was apparent that workers were reasonably aware of the risks associated with casual sexual behaviour and the detrimental effects to their health, yet were offered little options for harm reduction.

4.6.8. Health services

In Ibiza, the health services are divided between public and private clinics. In San Antonio there were a number of small private healthcare clinics and a slightly larger public medical centre on the outskirts, the 'Centre Salud'. The larger medical building was a walk in centre, catering for both tourists and locals and offering only basic healthcare at a minimum cost or free of charge. It was located just outside of the West End area, walking distance from the main drinking strip. In comparison, the smaller private clinics that were dotted around San Antonio claimed to have a greater variety of services available to cater to the health needs of tourists in particular, but charged higher fees. The main large public hospital on the island, 'Can Misses', is based In Ibiza Town, approximately ten miles from San Antonio. The health centre staff told me that tourists were sent here with more serious health conditions that required specialist care. During the secondary research trip I sought to investigate each form of health service offered. Simultaneously the research aimed to explore the most common health needs of tourists and casual workers. This would give me an idea of whether health needs were being met, particularly within the casual worker population.

I spoke to the reception staff at the Medico Galeno (a small private clinic) about what they were expecting for their evening. This was the quiet period, the 'calm before the storm'; later in the evening the clinic would be full of

young British tourists intoxicated on drugs and alcohol. Patients would flow in and out of the clinic until early morning. A common problem they faced was from tourists suffering heart issues because of excessive drug use. Many of those cases would be referred to the larger hospital in Ibiza Town, with the cost of the ambulance ride added onto their bill. This was stated to me in a very matter of fact way and I was taken aback by the lack of concern.

(Field notes, 2012)

First, I looked at the growing industry for private healthcare clinics in Ibiza, visiting one of the island's busiest clinics at the beachfront of San Antonio, the 'Medico Galeno'. The clinic was small with grey walls and a large reception desk that greeted you on entry, and there was a narrow corridor leading to treatment rooms in the back which were out of view. The lighting was stark white and I felt the space to be quite uninviting and the staff were not very approachable. A female at the reception desk informed me that the clinic charged for all healthcare, even if patients came in with an EU health card and the treatment was minimal. If a person should need an ambulance or a call out doctor the standard charge was 140 euros (approx. £120) plus the cost of the actual treatment. The service was obviously profit centred and I was told it was only open for around two months of the year, covering the busiest part of the summer season when they could make the most money. Patients were given forms to fill in which allowed them to claim back on their holiday insurance (if they have any). The clinic would leave most of the papers blank. Insurance companies will not pay out for drug and alcohol related issues, therefore patients were able to fill in whatever they want to enable them to claim back any expenses, and the clinic staff were very obliging with this.

I sat down at the bar and talked to the barman David. He told me that he had been in San Antonio since April and was working his second season on the island. I asked him about healthcare for workers and he said that he felt that workers party and take drugs so much that needing healthcare was sometimes a 'game of luck'. If the illness or injury was serious enough they would be forced to find the money for treatment, but most would rather wait to get free healthcare back in the UK. David felt it was only a matter of time before he needed to go to a doctor or hospital because of his lifestyle choices, but this did not deter him from staying for the whole summer.*

(Field notes, 2009)

The public health service at the 'Centre Salud' centre (opened in 2009) catered for basic healthcare needs, similar to NHS walk in centres in the UK. I chatted to a staff member standing outside of the centre smoking a cigarette. She told me that the centre was facing economic cuts, therefore lacking the facilities to deal with the influx of young holidaymakers every summer. As a result, they had to charge tourists without an EU health card a minimum of 80 euros per visit (approx. £65). Additionally, the centre did not have facilities to deal with serious drug and alcohol related illness or injury. Patients requiring major healthcare were referred and taken by ambulance to the Can Misses Hospital in Ibiza Town. I also spoke to two male ambulance staff members waiting outside the centre, they told me that they were already overwhelmed by the increasing number of call outs they were receiving each summer from young intoxicated holidaymakers. They did not know how much longer they would be able to cope without assistance; however they did not know where this would come from.

As previously highlighted, both in and out of work workers were encouraged every day to drink heavily and stay awake for long periods of time. This led me to think that peer pressure to use drugs and excessively party and the novelty of the Ibiza lifestyle could leave many with both short and long-term health problems. One major problem was the cost of healthcare, with workers agreeing that there should be a greater focus on cheaper and more accessible health services in San Antonio for longer-term temporary residents. In particular they felt that their EU health card was 'useless' as many common health problems did not qualify for free treatment or medication (see Appendix 3). Workers often spoke of not being able to afford to seek any form of healthcare, which was a precarious situation for them to be in. It was unclear if casual workers sought health insurance to cover their time spent in Ibiza and this was not investigated in discussions with workers. However, I did not speak to any casual workers who did not complain about the cost of healthcare, therefore can only speculate that casual workers may not have had enough disposable money to pay for healthcare costs upfront before claiming back on their insurance. Sceptical costs for treatments, coupled with a lack of trust in foreign health services was leaving workers with little choice but to wait until they returned back to UK to receive any healthcare. When writing up my notes at the end of the day I often thought about the burden



Centre Salud, San Antonio (<http://www.ibiza-spotlight.com/node/76422>)

that this could have on UK health services every summer for treatments for such problems as STDs, mental health issues and addiction. I also considered how this could ever be measured.

I was told of a story of a young male tourist who had his 'skull kicked in' and was found unconscious on the bar strip by a barman Alex. An ambulance from one of the private clinics had picked him up and taken him away. The tourist returned to thank Alex and told him that the clinic simply bandaged up his head and charged him 140 euros. The male had been very concerned about the actual extent of his injuries as he still felt unwell. Doctors had simply told him to avoid the swimming pool for the rest of the holiday and not to blow his nose at any point to avoid any bleeding to the brain. Yet he was told that he was safe to fly home. This*

experience had stayed with Alex and had given him negative views on the private health clinics in particular.

(Field notes, 2012)

It was apparent that workers felt that they were unable to look after themselves properly due to the high cost of living on the island, however they seemed reasonably accustomed to this. For example, eating healthily in the resort came at a higher cost than eating fast food due to the lack of reasonably priced supermarkets in the area, so many ate out at local takeaways or the large ‘McDonalds’ on the beachfront. Some workers I spoke to suggested that there should be a place where they can get cheap or free fruit and vegetables and access vitamins to improve their wellbeing and counteract the effects of excessive substance use (e.g. malnutrition). Nevertheless, I could not help but think that workers’ involvement in such behaviours in the first place raises the fundamental question of eligibility for such public health intervention. It also raises the question of responsibility, as publicly funded healthcare services in Ibiza are put under strain from young Briton’s alcohol and drug related illness and injury, therefore why should the Spanish people pay for this?

4.6.9. Ibiza 24/7: a local health initiative

During both fieldwork trips I visited a service called Ibiza 24/7, and spent time conversing with staff members and the founders of the organisation, who were originally from the UK. During the secondary trip I also spent two evenings observing their outreach staff while they looked after young vulnerable British holidaymakers on the streets. The following information was gathered from meetings with their founders at the Ibiza 24/7 centre and informal conversations with their street staff.

Ibiza 24/7 is a non-profit Christian organisation based in San Antonio. The organisation had a help centre based in the West End area just off the main bar strip area, and a retreat style accommodation on the outskirts of town for their staff and founders. Young Christians were invited annually to volunteer their services over the summer months to help run the Ibiza 24/7 centre, whilst simultaneously practising their Christian beliefs and relaxing at the retreat.

Ibiza 24/7 started in early 2000 and was just a small prayer group based in San Antonio, before then it had only existed in the UK. Its funding had always come from one off donations from related organisations and individuals as well as from the church.

Subsequently, donations were scarce and their funding sources were constantly exhausted.

Ibiza 24/7 is very clear about the services it provided and their limits to providing care. It catered only for '*the physical, emotional and spiritual needs of vulnerable people in San Antonio*' (Field notes, 2012). Outside of its work in the centre it is faced with the daunting task of caring for young British holidaymakers and casual workers on the street and their ever increasing needs due to excessive use of drugs and alcohol during their stay.

Ibiza 24/7 did not have medically qualified staff, and therefore could only provide basic healthcare to those in need. There was a very fine line that they could not cross when dealing with the young British tourists in particular. Their service provided staff that were there to chat to vulnerable people and provide emotional support where possible. The staff were able to escort intoxicated individuals back to their apartments and hotels and they were able to contact local health and ambulance services for people in need of treatment. Ibiza 24/7 only used the public health centre services and had a good working relationship with their ambulance teams. However, the assistance of the local public health centre was becoming more limited due to funding cuts and staff shortages.

Tracey, one of the Ibiza 24/7 founders, told me that tourists were never taken to the private medical centres by Ibiza 24/7 staff as they could be charged up to 400 euros for even basic treatment. She felt that their priority was to make a profit rather than provide effective healthcare. The private clinics had been known to park their ambulances around the West End bar street so that they could pick up drunk and vulnerable tourists and charge them unnecessarily for a trip to the medical centre. This was interfering with the Ibiza 24/7 work ethic and made for an uncomfortable competitive atmosphere.

(Field notes, 2009)

Ibiza 24/7s' drop in centre was in the busy West End of San Antonio, just off the main bar strip, where they offered an internet service and an area for young people to congregate and socialise. Their centre was modern and decorated with bright colours with comfy sofas, a table tennis area and computers for free internet access; it reminded me of a small youth club. In offering this service they hoped to provide a safe haven for young people who were in need of rest and recuperation and an escape from the chaos around them. The drop in centre had a good supply of leaflets and literature on sexual health, substance use and alcohol abuse, however staff were unable to personally advise as they were not qualified. At the back of their centre they had a dedicated room for private counselling and informal chats that tourists, casual workers and locals were said to visit when they were feeling overwhelmed, run down or in need of private advice. The centre also offered free massage, relaxation techniques and 'chill out' CDs. The centre was once able to hand out free condoms to workers and tourists yet their suppliers and funding had since been diminished.

Ibiza 24/7 classed themselves as a small religious group, therefore they were not willing nor financially able to take full responsibility for the care of vulnerable tourists and casual workers in San Antonio. Additionally, the service only recruited a small number of Christian volunteers each year, and did not seek to recruit any healthcare professionals. Furthermore, the group did not want to lose sight of its religious beliefs and purpose by becoming a large-scale harm reduction initiative.

The Ibiza 24/7 model for providing support to vulnerable people was kept quite simple, with staff members going out to walk the streets of San Antonio four nights a week, then providing a response contact number two nights a week, with Sunday as their day off for prayer and recuperation. The hotline number was given to local bars and restaurants businesses as a point of contact should any problems arise or if any vulnerable and intoxicated people were identified. Staff always went out in pairs to walk around San Antonio for safety, each pair carrying a mobile phone to keep in contact with both the Ibiza 24/7 hotline and other pairs walking around the resort. This enabled them to have eyes and ears in all areas of town. There were usually around eight volunteers out on the street at a time, all wearing black t-shirts with the Ibiza 24/7 logo on the front. The service strived to present themselves in a professional manner with each member of the team carrying water, a map of all hotels in the area and log-book to record any incidents and the names and addresses of people they may help. Ibiza 24/7 also carried cards with their contact details on, which were often left with intoxicated individuals so that they could identify who helped them home or to hospital.

One of the most active services was their 'Vomit Van'; a clearly labelled vehicle provided to take people back to their hotel or apartment that were lost, intoxicated or passed out. In particular, the service helped those walking home alone who were at risk of rape or mugging, or had already been attacked. The van was air conditioned and kept cool to keep intoxicated

people conscious and therefore able to talk. The Vomit Van was also used to escort those in need home from hospitals and medical centres once they had been treated in order to take the pressure off the local ambulance services. This service in particular was greatly supported by local ambulance and police services that regularly checked on the Vomit Van to make sure everything was okay and if they required any assistance.

While out observing Ibiza 24/7 staff a young male was found asleep under a restaurant table in the early hours. He turned out to be British and no older than 18 years old. He had been abandoned by his friends and was throwing up repeatedly so taxis would not take him to his hotel. He did not know where he was or how he got there, but he thought he had been there for over an hour at least. He was missing his phone and wallet which implied that he had already been mugged. He was very confused and disorientated. The Vomit Van immediately came to collect him and took him back to his hotel.

(Field notes, 2012)

The staff at Ibiza 24/7 tried to keep a constant presence around San Antonio, particularly around the busy West End drinking strip where they were most needed. In doing so, they liked to form working relationships with staff working in bars and nightclubs in the area. They regularly approached young British casual workers to both provide a point of contact for help for tourists, but also to provide support and advice to the workers themselves. The centre was commonly frequented by casual workers during the day that needed advice or just a quiet place to relax. Similarly, the Ibiza 24/7 staff liked to form relationships with local

security staff and bouncers in order to help provide a safer environment for tourists and to enable both parties to aid each other in the removal of vulnerable persons from bars and clubs. There had been a notable increase in violence involving security staff and tourists and the use of authoritative aggression on the drinking strip, for example in the removal of drunken patrons from premises. In communicating regularly with bouncers and providing a calm voice of reason, the Ibiza 24/7 staff hoped to decrease this unnecessary violence in the resort.

Ibiza 24/7 was there to provide help to vulnerable people, however its volunteers were unable to use any force or coercion to those in need. If intoxicated individuals refused to seek medical attention or chose to put themselves in a dangerous situation they were unable to do anything about this. The staff could only provide a certain level of advice to the individual or the persons accompanying the individual and try to guide them in the right direction. This was proving particularly troublesome for staff who were faced with individuals who had been beaten or raped and were refusing to seek medical or police attention. Staff had witnessed quite disturbing scenes of violence, drug overdose, alcohol related injury and so on.

Similarly, they were often put in danger from aggressive individuals and the threat of being caught up in violent situations involving intoxicated parties. Ibiza 24/7 staff were increasingly unaware of the types of substances that individuals were consuming and the strength and potency of each. This meant that there was an added level of caution to be taken when dealing with intoxicated individuals. This was proving to be hindering the level of service they could provide without assistance from local authorities.

While walking down the beachfront, staff came across a young female who looked about 18 years old, and was quite clearly under the influence of

drugs. Her dress was ripped down the front and she was exposing herself, and her make-up was smeared all over her face. There were signs that she had fallen as she was covered in grazes and dirt. She looked like she could have been potentially raped. She claimed that she had had her belongings stolen. She had no idea where she was, where she was staying or where her friends were and was struggling to communicate. The team sat with her and offered support but were unable to escort her to the police station without her permission.

(Field notes, 2012)

Ibiza 24/7 staff felt that there was a great need for cooperation with local bars and clubs in providing safer and more responsible drinking restrictions, such as the non-service of drunk patrons or those who are lost, alone and vulnerable. Additionally, they felt that there should be first aid trained workers within bars and clubs as a basic necessity. However, Ibiza 24/7 were unable to implement such measures without the support of local authorities and businesses, and in a profit led industry the bars and clubs were not willing to cooperate.

Throughout my time spent with Ibiza 24/7 I was increasingly aware of how stretched their services were and the limits to which they could dedicate their time to street work in particular. When reflecting on my visits, I often considered whether this service could be used as a model for future initiatives in the way that they embraced the local substance use cultures. Ibiza 24/7 did not attempt to stop such behaviours, but worked to solely reduce harm and provide advice to enable individuals to make responsible decisions. However, I was aware that their service could be reduced to simply providing basic physical and emotional support.

4.7. Discussion of ethnographic findings

Previous ethnographic studies have described Ibiza as a ‘temporary wild zone’ with a ‘carnivalistic’ atmosphere which is built around the commodification of hedonistic experiences (Briggs et al., 2011a; Briggs, 2012). This could not be more relatable to the resort of San Antonio; a place where the nightlife industry is the crux of the economy. This party lifestyle is now extremely accessible to the average young person due to the advent of cheap flights and package deals, widening the opportunities for British tourists to seek temporary residence for whole summer seasons. Studies have hypothesised that tourists choose to actively take part in risk behaviours to escape the constraints of home life (Bellis et al., 2002; Carter et al., 1997) or construct meaningful memories and establish an identity (Briggs et al., 2011a). The Ibiza identity is clearly one of uninhibited freedom to reach new personal hedonistic limits.

My findings showed that working in Ibiza was viewed by young people as being both a brave and respected experience and one that many could not handle. Yet ‘surviving’ an Ibiza season (even for as little as a month), made individuals a distinguished part of an elite group of extreme hedonists. San Antonio clearly has a reputation as being one of the most exciting yet punishing places to work. Casual workers in Ibiza were motivated by extreme hedonistic exploits; attending the biggest and best nightclubs, seeing the best DJs and taking the best drugs. Status and power was built upon such things as working in the trendiest bars and nightclubs, working the most seasons, or even dealing the most potent drugs. This was the cultural capital of casual workers (Bourdieu, 1986). One could be a low skilled disrespected worker in the UK, yet be the most respected drug dealer in Ibiza. With a criminal justice system failing to admonish small-time dealers, this career option is becoming far too attractive. Drug use and drug dealing was so openly apparent in San Antonio that individuals appeared to become desensitised. Consequently, this raised questions about the effects that

this may have on individuals returning home to the UK and their views of right and wrong, acceptable and unacceptable.

Casual workers in San Antonio were existing in a society where individuals are allowing themselves to be pushed to their limits in the name of reaching their pleasure-seeking highs. Instead of seeking the safety and security one might have at home, workers were allowing themselves to reach states of poverty, homelessness and ill health all in the name of 'being' an Ibiza worker. Such behaviour can be described as 'liminal' as workers are no longer part of social structures at home and are existing in a space whereby normal social codes and boundaries are suspended (Andrews & Roberts, 2012; Bell, 2008; Bloor et al., 1998; Eiser & Ford, 1995; Graburn, 2004; Shields, 1990; Thomas, 2005; Wickens & Sonmez, 2007). This means that standards of living and personal health that were adhered to at home may no longer be relevant in this space as there are no authoritative figures such as peers or parents, or job responsibilities that may exercise control over such issues. In such liminal spaces the connection to such structures is suspended, therefore individuals may feel less of a need to uphold moral social behaviour (Shields, 1991). Casual workers are in a 'liminoid' state whereby they have chosen voluntarily to put themselves in such positions and make the decision to stay in Ibiza in a space without rules or boundaries (Turner, 1982). Yet as individuals choosing to work in Ibiza are all sharing this experience of the Ibiza lifestyle they may exercise a level of homogeneity in the activities and lifestyle that they share, much like Turner's descriptions of 'communitas' (1969).

Likewise, in terms of casual workers, Bakhtin's theory of 'carnavalesque' is a suitable description of casual workers' participation in risk behaviour. The theory describes a type of 'festive madness' where individual's worlds are turned upside down and they enter a space where 'anything goes' and '*traditional hierarchies are set aside*' (Bakhtin, 1984:158). Nevertheless, it must be questioned whether this is more applicable to first time workers at

the beginning of their stay. As described in the findings, seasoned workers tend to take part in less nightlife activity and risk taking, such as substance use, compared to new workers who may treat Ibiza like a party playground. Additionally, it is questionable whether this theory can be applied to such long term inhabitants of Ibiza, as it would be expected that the 'festive madness' would eventually wear off, or at least to an extent. It could also be questioned if casual workers behaviour may lead to a 'burn out' where risk behaviour declines throughout the summer period as their physical and mental health is affected.

Unlike short-term tourists, casual workers had to adapt and acclimatise to their environment to enable survival over a longer period of time. The literature review highlighted that there was a lack of research looking at the social purposes of drug use and the reasons and motivations for polydrug use. Yet, what was found in this study was that casual workers were using multiple substances as a means to both stay awake and keep employment, and to have the energy to stay up all night partying. In choosing to work in Ibiza and ensuring longevity in the resort, workers were 'making do' with the infrastructure around them. There was a lack of accommodation to meet the demands of workers, so they were sharing very small spaces with strangers. Some workers were homeless and did not have enough money to eat so they shared what they could get with others. To many outsiders this could be seen as 'third world' type survival not expected to be found in an exclusive destination in a developed country. Yet young British workers had no intention of flying back to the UK to the comforts of their own home or the security of regular work. To quit an Ibiza season would be seen as a personal failure, to survive an Ibiza season is a personal triumph respected by many.

The provision of healthcare in San Antonio did not meet the needs of casual workers who were demanding short-term solutions and quick fixes. Their priorities lay elsewhere when it came to seeking harm reduction measures and treatment, with workers waiting to receive healthcare back in the UK. Fear of foreign health services, costly charges and lack of trust in

practitioners are all factors that have contributed to a culture of denial and resistance to seek healthcare. Yet in an environment where excessive drug and alcohol use and casual sexual relationships is inherent, this may lead to both short and long term health complications that may have consequences for individuals future physical and mental health. Although the Ibiza 24/7 service was in existence during both study periods, it is questionable if this service may only be reaching the tip of a wider problem that needs tackling on a deeper level.

Study limitations

Studying a population of casual workers in a destination like Ibiza was not an easy task, with high rates of intoxication and blurred divisions between casual workers and short-term tourists. This led to continual self-reflection throughout the research process of my position as a researcher and the participants as ‘others’ (Goffman, 1971). As an ethnographer, it is important to be continually reflective about approaches that may be used, therefore, it is useful to describe the study limitations in detail. In doing so, this allows the research to be placed within one space and time and be identified as ethnography of casual workers that exist within that time frame, rather than generalising. It must also be acknowledged that my field notes are subjective of my interpretation of the study arena, and therefore are not replicable.

Throughout the initial research trip in August 2009, difficulties were faced in creating opportunities to observe and converse with casual workers due to the fact that I was a sole researcher. Casual workers in Ibiza are renowned for working long antisocial hours, mostly in the evening, and sleeping for much of the day. For personal safety reasons research could only be conducted in daylight hours, restricting the amount of data that could be collected about nightlife and workers in bars and nightclubs. To overcome this, a secondary trip to Ibiza was arranged to coincide with the presence of fellow researchers in San Antonio who

were conducting research in a similar area. This allowed for the safe collection of data in the evening and the ability to attend nightlife arenas as a group. It also increased fluidity and naturalness to group conversations and eliminated previous apprehension of approaching groups of casual workers alone.

As previously mentioned in the study methodology section, we cannot always predetermine the extent to which the researcher may participate as it will be determined by the researchers' own experiences (Bernard, 1997). The disclosure of my role as a PhD researcher may have caused barriers in building relationships with casual worker participants. The nature of participant observation is to engage in such a way with participants that their behaviour is not affected by the researcher's presence. In making myself known as a researcher, participants may have been apprehensive to disclose personal information about themselves and their behaviour, and may have behaved in a manner outside of their natural everyday behaviour. Drug use and sexual behaviour are both sensitive topics that can generate levels of stigma due to their deviant and illegal natures. Situational encounters where my identity was not initially disclosed took place on a number of occasions as conversations and occurred naturally and spontaneously without any planning or foresight. Therefore, notes from many conversations could not be used due to the nature of the content and the lack of verbal consent from participants.

The nature of ethnographic research requires a level of participant observation and immersion into the culture of the population being studied (Bernard, 1994; Fabian, 2002). However, in the case of casual workers, implicit immersion into their everyday lives may require a level of behaviour that would be uncomfortable or unfamiliar for a researcher. For example, dressing scantily in public areas and consuming high levels of intoxicants. As highlighted earlier, previous studies have adopted methods of drinking alongside informants to establish credibility and rapport (Briggs et al., 2011b; Blackman, 2007; Joseph &

Donnelly, 2012; Morean, 2005; Wilson, 2005). Yet this can affect the ability of the researcher to collect credible data, can jeopardise the consent process, and affect the safety of the researcher and participants. When conducting research in bars and nightclubs, tourists and workers were consuming large amounts of alcohol, so therefore choosing not to consume alcohol may have inhibited the amount of socialising with workers outside of their workplaces. It may have also restricted the types of places I was able to visit, such as worker apartment parties. However, particularly in the first research trip, I did not want to put myself in vulnerable situations that would jeopardise the collection of valid data. The same applied for encounters where I may have been witness to casual workers consuming illicit substances, in which case I removed myself from the situation promptly. In all cases, I was very aware of my formal position as an outsider and a researcher, which in turn did not allow me to gain a full comprehension and deep understanding of casual worker life to the level of full immersion. This is an ethical question that as a researcher I must consider if taking part in future research around cultures that involve risk behaviour such as excessive drinking alcohol use. Yet, at this stage it is useful to highlight such issues as a continuing conversation to have within this field of research.

When taking part in informal conversations and making observations there were many difficulties when encountering intoxicated tourists and casual workers. If individuals were clearly intoxicated they were not approached for safety reasons, and to simultaneously minimise the collection of incorrect or invalid information. Conversations would often have to be politely suspended if it was suspected that the participants were drunk or under the influence of drugs. In such cases, any data recorded into notebooks was not included in the write up of findings due to the potential lack of trustworthiness of statements. Nevertheless, identification of intoxicated individuals was down to my own subjective opinion, therefore, it cannot be guaranteed that drunken participants were not included in the data. As identified

by Briggs et al, (2011b), the nature of doing research in nightlife-orientated holiday destinations often means that talking to intoxicated patrons can be unavoidable.

The high price of nightclub entry in and around San Antonio (approx. 50 Euros per nightclub- £42) restricted the amount of data collection that could take place in such premises. This may have limited the amount of information collected on casual workers that work within the nightclub industry. To overcome this casual workers and locals were consulted to identify individuals who worked within this industry and efforts were made to make contact with such parties outside of their workplace. Fieldwork was restricted to the resort of San Antonio, in particular the beachfront and West End bar area. This means that data collection focused only on these centralised areas. Ultimately, the ethnographic findings only provide a snapshot of workers in one resort within two specific periods in August 2009 and July 2012.

There is no particular right or wrong way to write field notes, however, there are many factors that may affect their use and applicability. Where possible, field notes were taken during participant observations and informal conversations, however in most cases the research was covert and notes were made at the end of each encounter or end of the day. In these instances, the passage of time may have affected the quality of the notes and the extent to which details were remembered and interpreted correctly (Hammersley & Atkinson, 2000). Nevertheless, the use of notepads and jotting down in most encounters would have proved disruptive to the natural flow of conversations, and may have raised questions on the nature and motive of my participation. In this case, expandable notes were taken where possible using bullet points that could be written up at a later stage (Spradley, 1980).

A schedule was set up to expand field notes at regular intervals throughout the day. This offered a chance to reflect and review the field notes throughout and to begin to pick out

themes, encouraging a continual internal dialogue. In hindsight, the use of recording devices may have aided the collection of data in some situations, such as when chatting to large groups. However, it was decided that this method of recording would not be used as it may have affected the amount of information that was disclosed and may have adversely formalised the research setting.

Due to time restrictions, some detail within the field notes may have been sacrificed for the purpose of keeping the research more focused on particular themes that were being drawn out throughout the research process. However, the research strived to include as much contextual observation as possible to add depth to the data. It also must be considered that in the nature of taking field notes meanings attached to the data may be subjective and may involve a degree of ethnographer's personal feelings and opinions.

Finally, in hindsight of this research, it would have been useful to map the area in which the research took place. Andrews (2008, 2012) discussed the advantages of using maps as part of participant observations as a way to feel more orientated in the field and to feel more grounded and in control of where the research is taking place. She highlights that maps can also be an invaluable tool for data analysis, and in terms of my own work would have provided a better outline of the social context from which I was working. This is especially relevant when doing ethnographic research in a large open space, rather than an enclosed area (Andrews, 2012). In her study of tourists in Magaluf and Palma Nova, Mallorca, Andrews mapped out hotels, bars, beaches and other such features of interest to provide social and geographical depth to her enquiry. It can also be used as a tool for memory, for example for recounting encounters that took place in certain areas. Without such maps of the areas of study the research may not be as grounded in the space and place as I would have wished for. The findings are not necessarily linked to any particular space, such as the beach

or West End area, however the study would have benefited from adding this as another dimension to the analysis.

4.7.1. Conclusion

In attempting to answer the research question (2) of '*what are the everyday behavioural norms and experiences of casual workers that may affect involvement in risk behaviours and use of health services?*' this study has provided a detailed account of casual workers' behaviours within their social, cultural and environmental context. Providing statistics alone did not provide an adequate explanation of why risk behaviours were actually occurring and why such high levels of substance use and sexual behaviour were measured. This exemplifies the importance of combining methods to gain a more holistic understanding of risk populations; the triangulated data of both the quantitative and ethnographic studies will be discussed in further detail from Section 2.4.

In particular, it is important to understand where health services may be failing; or where there are existing barriers to accessing health information, advice and treatment. In the case of casual workers, it is clear that their culture is complex and dependent on the setting of social norms and values. This can determine the pathways to healthcare; for example, if casual workers are resistant to receiving treatment due to scaremongering amongst the population.

This chapter in particular has attempted to address why casual workers should be viewed as a higher risk population than regular short-term non-working package holiday tourists in this area. This can be viewed in terms of their length of stay, types of socialisation, access to substances, job markets and health seeking behaviours. Most importantly, the chapter has

identified that there is a criminal element to being a casual worker that could have the potential to greatly affect behaviours on return home.

For that reason, it is vital that necessary stakeholders such as the Foreign Office, local and national health authorities, holiday companies and casual workers themselves are able to work together to provide tailored services that are contextually appropriate.

4.8. Final discussion of triangulated findings

The study of young British casual workers in San Antonio, Ibiza, initially set out to collect quantitative data on their sexual behaviour and drug use whilst residing in this notorious nightlife resort. This was based on previous quantitative studies in this area (e.g. Hughes & Bellis, 2004, 2006). It was noted at that time that only a small number of studies had been published that had used qualitative methods to understand and describe the behaviours of tourists in resorts (e.g. Hesse & Tutenges, 2008; Hesse et al., 2008). For that reason, during the initial trip to Ibiza in 2009, ethnographic enquiry, including observations and informal conversations, was also used to gain an understanding of the meanings behind the quantitative data being collected. However, it was clear from the outset that to fully comprehend the behaviours and attitudes of individuals on the island, further in depth exploration was required. On return from the initial trip, a number of ethnographic studies had taken place measuring behaviours of tourist in Ibiza (Briggs et al., 2011a, Briggs et al., 2011b); which inspired a second fieldwork trip to Ibiza in 2012 to continue investigating casual workers. This discussion section serves to summarise and highlight the main findings from both studies in a combined and comparative manner. The discussion will then seek to provide an outline of recommendations for further research and the implementation of health initiatives for Ibiza workers as a high-risk population.

Using both quantitative surveys and qualitative ethnography has allowed for a better understanding of the substance use and sexual behaviours of casual workers in Ibiza. As described in the research methodology, the benefit of triangulating data is that it contributes to the depth of the research and allows for a broader range of issues to be addressed in detail (Decrop, 1999; Finn, 2000). In terms of fulfilling the research questions (1 & 2), the combination of both studies has allowed for an in depth explanation of the substance use, sexual and health seeking behaviours of casual workers as a specific high-risk tourist type; it

has allowed for an understanding of the social, cultural and environmental factors that affect risk behaviours and access to health; and it has allowed the research to make substantive links between substance use and sexual behaviour. This has formed the beginnings of a contribution towards the over-arching aims of the thesis. The following discussion will firstly discuss theoretical implications of the study, then triangulate the findings from both studies and describe how the findings are relatable, and provide depth and consistency throughout the research process; and secondly discuss the theoretical implications of the study.

Ibiza has a reputation of being a major international dance music destination, attracting groups of young people interested in recreational drug use. With 55.3% of participants reporting using ecstasy and cocaine in the UK prior to arriving in Ibiza, it is clear that Ibiza is attracting a large proportion of drug using casual workers. These figures are far higher than the prevalence of use reported at home in the UK general population (2009/10, cocaine 5.5% and ecstasy 4.3%; Home Office, 2010). The level of use whilst in Ibiza is only heightened, with findings showing a general increase in illegal drug users in Ibiza in comparison to previous users in the UK (71.2% to 85.3%). Ultimately, illicit drugs can be easier to access in Ibiza than in the UK, with many different sellers trading substances openly on the street, everywhere you may look. This was represented in the findings with the amount of users increasing across all substances, highlighting increases in accessibility. Similarly, the very social core of the worker population is based around a culture of drug use. For that reason, casual workers who reside in San Antonio for a longer period of time could be more likely to normalise this type of behaviour, in particular if they are socialising with other worker who are consuming substances on a regular basis.

Findings from the quantitative study showed the high level of recruitment or relapse into drug use in Ibiza; with 52.6% of those using illegal drugs in Ibiza reporting that they used a substance in Ibiza that they had either never used or not used in the previous 12 months in the

UK. Such a high level of new users shows that Ibiza is a potential breeding ground for new substance using populations of young people. First time workers in particular were identified as new frequent drug users, with many losing their ‘pill virginity’ in Ibiza. Impressionable new arrivals are likely to be integrated quite rapidly into a drug scene led by seasoned workers who are frequent users with easy access to various substances. Trying new substances can be seen as a necessary activity that initiates first timer workers into being fully fledged ‘Ibiza workers’, much like a ‘rite of passage’ as described by Van Gennep (1960). Peer pressure to conform to such norms and the desire to fulfil the complete Ibiza experience, means that individuals can be easily coerced into becoming regular recreational users. In time, this could be a drug habit that continues to grow and gather pace throughout an entire summer in Ibiza. Drug use is not seen as a deviant action, but a rite of passage and a way to ensure survival through the tough summer season. This raises the question of whether non-drug users would be capable of fitting into this self-medicating population. Further research would benefit from observing changes in individuals’ drug use behaviours over an entire season in different resorts where workers may migrate over the summer season, in particular looking at first time workers. Furthermore, studies must be implemented that take into account the effects that levels of recruitment to new substances might have on individuals’ substance use behaviours on return to the UK.

The most prominent increase in drug use was found for ketamine, with the proportion of users notably higher in Ibiza (54.7%) compared to the UK (30.6%). Just under half (46.2%) of the ketamine users in Ibiza had been recruited to using the drug or had relapsed into using having not used in the previous 12 months at home. The ethnographic data supported this, with casual workers reporting that ketamine was the cheapest and most readily available drug on the island. Recreational ketamine use was found to occur most notably in house/apartment parties within worker accommodation blocks. Ketamine was described as the most potent

drug available on the island, offering a sustained 'high' with each use, without having to increase the dosage. Consequently, ketamine is a popular drug amongst first time workers who are generally more sociable, attend more house parties and are lacking a secure income. With such a high amount of ketamine use occurring in Ibiza, harm reduction messages are needed that specifically address the health problems associated with this popular party drug. Prolonged ketamine use, for example, has been found to cause long-term health problems such as bladder control issues (Wood et al., 2011) and mental health issues (Dillon et al., 2003; Muetzelfeldt et al., 2008). Nevertheless, with the advent of new legal highs and changing fashions in UK drug markets (Brandt et al., 2010; Winstock et al., 2010), it may only be a matter of time until another drug replaces ketamine as the most popular, cheap and potent drug on the island.

Findings not only showed a general increase in drugs users, but also an increase in the frequency of drug use in Ibiza for all users across all substances in comparison to frequency of use in the UK. For instance, 29.8% of participants used ecstasy at least twice a week in Ibiza whilst only 1.2% used twice a week in the UK. Additionally, the findings suggested that there is a level of polydrug use in Ibiza with individuals using more than one drug at the same time, with 74.7% reporting using multiple drugs in Ibiza. Such frequencies are accountable to the specific lifestyle that casual workers have; with individuals using particular substances to cater for their everyday needs. Increases in the frequency of and multitude of drug use can be conducive to the need to stay awake for long periods. Employers are increasingly seeking workers that are confident, energetic and sociable; drugs such as ecstasy and cocaine can enhance such desirable personality traits. Job markets in Ibiza are competitive and a regular income can be a rarity. Therefore, the need to stay alert and energetic is greater in order to secure permanent and reliable employment. Drugs are consequently not only part of the culture of workers in Ibiza, but also supporting the local economy. As a result, casual workers

may gain drug habits that are both recreational and functional for their survival in workplaces on the island, especially because of fierce competition for jobs. Furthermore, if such behaviour is common amongst casual working populations and social networks within them then this type of drug use can easily become a socially acceptable method of daily functioning that may have longer term effects on people's general attitudes to drug use.

Alongside employment, workers were still managing to party almost every day for the entire summer; with two thirds of participants reporting that they were visiting bars five or more times a week (62.5%) and nightclubs 2-4 times a week (63.7%); further increasing the chances of frequent recreational drug use to simply maintain the pace. This may be in order to not miss out on the full Ibiza experience of partying every day and night, visiting the best nightclubs, seeing the best DJs and attending the best parties. Continued use of multiple substances over a condensed period could lead to potentially dangerous health concerns, such as long term mental health issues (Rasic et al., 2013; Sumnall et al., 2010). Furthermore, frequent polydrug use in tourist resorts has been associated with increased violence (Hughes et al., 2009) and risky sexual behaviour (Downing et al., 2010). As a concentrated population of frequent drug users in a demanding environment, casual workers must be recognised as a particular high-risk subgroup for subsequent health and social problems. Yet it must be acknowledged that in looking only at Ibiza, this may be a specific problem that is only attributed to this 'party island'.

As well as drug use, casual workers are facing health and social problems through excessive alcohol use and drunkenness. Proportionate increases in the frequency of alcohol use were measured, with 69.0% of workers using alcohol more than five days a week, in comparison to 9.9% using more than five days a week back home in the UK. Such increases may occur due to the increased exposure to and availability of alcohol on an everyday basis, both in the workplace and socially. Casual workers also reported that they often purchased alcohol from

off licenses in San Antonio and drank in their apartments before going out to bars and nightclubs. Studies have identified that ‘pre-loading’ can lead to individuals being involved in instances of violence, sexual assault, and can contribute to increased hospital admissions (Hughes et al., 2008; Measham & Brain, 2005; Quigg et al., 2010). However, it is unclear if this has the same effect in Ibiza, and if there are health services available to deal with the consequences of this binge drinking phenomena.

The ethnographic study found that bar owners ply their staff members with alcohol to simultaneously appear generous and to increase the confidence and energy of their employees. Alcohol can also be used as both a facilitator and a bargaining tool to coerce workers into behaving promiscuously with customers to attract them into bars and nightclubs. This breeds an unhealthy relationship with alcohol as workers may become vulnerable to potential sexual exploitation within their workplace, with inhibitions purposefully loosened through the use of intoxicants. Yet, if excessive alcohol use were to lead to a high turnover of staff due to illness or hangovers, there is clearly a large pool of workers that would be willing to take their place, therefore bar owners do not need to be concerned. Young workers in the UK may be protected by employment laws that prevent such behaviours, however in Ibiza it appears that moral boundaries are increasingly blurred within unregulated nightlife industries. In turn, such employment markets are creating a permissive environment for excessive alcohol use within these temporary summer working environments. However, there is a relaxed attitude towards employment laws and the registration of workers, and it is unclear if this will change anytime soon. Therefore, this problem stretches as far as local and national policy review, and may only be curbed with the introduction of further on the ground monitoring and checks with punitive consequences.

On the other hand, the consumption of free or discounted drinks in the workplace is can be welcomed by casual workers on a budget who cannot afford the high prices of drinks in bars

and nightclubs. Therefore, workplace drinking can also be seen as a method of pre-loading. High levels of alcohol use in Ibiza may also be attributed to the social life of workers outside of their working environment. Workers commonly purchase alcohol from off licenses and pre-load on alcohol at parties or visit bars that offer worker discounts on alcohol. Despite generally having a low income level, casual workers are still partying at bars and nightclubs on a nightly basis. As a result, drinking alcohol is an activity that is both unavoidable and inherent to the worker daily schedule, especially in order to socialise and make friends. Casual workers are a potential population of dependent alcohol users, with levels of need increasing the longer the worker may inhabit the island. Physical and social dependency on alcohol can lead to an increase in chances of acquiring heart and liver problems (Rehm et al., 2003; Room et al., 2005). Furthermore, increased levels of alcohol intake in tourist resorts have previously been found to contribute to violence and disorder (Hughes et al., 2008). For that reason, casual workers are a key target for alcohol-related health interventions that are different to initiatives that may be aimed at tourists. Additionally, alcohol-related harm reduction measures that take into account exploitation, violence and sexual vulnerability must be implemented within worker populations.

As a high drug and alcohol using population, casual workers have a high level of spend, and little disposable income. Low wages mean that many casual workers are supplementing their income by taking part in low level drug dealing in Ibiza (Briggs et al., 2011b; Briggs, 2013). Workers play quite a substantial part in this industry, dealing drugs to fellow workers, tourists, friends and work colleagues, often overtly on the streets or beaches. Without numerical evidence, it is unclear of the actual extent of such behaviours; but this could be difficult to measure. For some, drug dealing is their only means of income, and many are earning an income far above anything they might receive back in the UK, therefore making it a popular choice. Additionally, such wide and easy availability of substances has served to

perceptively decriminalise the notion of drug use and drug dealing, and open and uninhibited distribution has become normalised. It is commonplace to have friends within worker social networks who are drug dealers, which again can further normalise this type of behaviour and make it seem socially acceptable.

The study did not explore criminal justice systems in Ibiza in any detail, however it became clear from the research that casual workers are little concerned with the punitive consequences of taking part in low level drug dealing. Police presence on the streets of San Antonio was largely minimal and minor punishments were given to those taking part in low level drug dealing. Consequently, a permissive atmosphere for overt illegal activity appears to have been created that has become an inherent part of everyday life in Ibiza. Despite this, there are few services available to advise or support that are relevant to both drug use and drug dealing, therefore this high risk population of users are without guidance or protection, and few national or UK based interventions exist to moderate their behaviours. The consequences of this have recently been reported in the UK media with young British casual workers getting involved in high level drug dealing gangs (see Appendix 4).

In addition to excessive alcohol use and involvement in drug cultures, findings built on a previous study that had identified casual workers as being at high risk of sexual health problems (Hughes & Bellis, 2006). A high level of sexual activity was measured in Ibiza, in particular the number of sexual partners casual workers had over the summer season. The majority (89.6%) of those arriving without a sexual partner or spouse had sex in Ibiza, whilst 71.7% of these had sex with more than one partner during their stay, with the mean amount of partners at 0.82 per fortnight. Findings showed that 50.0% of participants had unprotected sex, and of those 58.7% had unprotected sex with multiple sexual partners. Daily contact with fellow casual workers, tourists and locals increases the chances for sexual encounters within the resort. The substantial amount of socialisation that takes place on a daily basis with new

acquaintances, both in and out of work environments, means that sexual relationships are often accelerated and casual sexual encounters are commonplace. Consequently, casual sex and general promiscuity of males and females appears to become further normalised into the everyday experience of being a casual worker. Such levels of normalisation and exposure to highly sexualised environments whilst in Ibiza could potentially affect individuals' attitudes towards sex, in particular casual sexual encounters, on return home to the UK. The ethnographic fieldwork trip failed to uncover any adequate evidence to support the figures from the quantitative study on sexual behaviour. This may have been because of the sensitivity of the topic; or perhaps the lack of opportunity to engage in conversations about sex. Nevertheless, the ethnographic study has built upon the work of Briggs et al, (2011b) and their ethnographic study of sexual behaviour of tourist groups in Ibiza, further identifying casual workers as 'key players' in sexual activity.

In San Antonio, there are numerous strip clubs and a clear presence of prostitutes in the West End bar area. Previous studies have highlighted that young tourists are regularly visiting strip clubs whilst on holiday and coming into contact with sex workers many of which are not from their own country of residence (Briggs et al., 2011b; Hesse & Tutenges, 2011). This can lead to increased risk if sexual partners are from countries that have high HIV transmission levels and individuals are not using condoms (Cabada et al., 2009). However, this study did not measure such activity. It is clear that young British casual workers in Ibiza are finding employment in such establishments; nevertheless, it is unclear if they are taking part in transactional sexual activity. With many workers unregistered within their workplaces, there is potential for exploitation of workers within this industry, and little is known about protective measures in place for their safety. Further qualitative study of this area may be ethically challenging, but beneficial.

Frequent drunkenness was found to be a strong predictor of sexual risk taking, including having had multiple sexual partners in Ibiza. In such an environment alcohol can be used to facilitate sexual encounters by raising confidence and lowering inhibitions. However, it can simultaneously reduce individuals' ability to make informed decisions about sex and using contraception (Bellis & Hughes, 2004; Bellis et al., 2008; Thompson et al., 2005).

Consequently, of those arriving in Ibiza without a sexual partner, 93.4% reporting having had unprotected sex; and 89.7% of those reported being under the influence of alcohol at the time. It is probable that this is contributing to increased levels of sexually transmitted diseases (STDs) spreading throughout populations on the island. As a result, such increases could be adding to the number of sexually transmitted diseases being brought back home to the UK. It was found that of the participants arriving without a sexual partner and having had sex, only 11.2% received a sexual health check-up whilst in Ibiza. Consequently, many STDs may be lying dormant for extended periods of time, and without immediate treatment can lead to long term health problems such as infertility (Abdullah et al., 2004). Previous studies have used GUM clinics as a location for post travel measurement of sexual health (e.g. Carter et al., 1997); therefore, a follow up survey of this kind may have been useful in identifying if any of the workers involved in the survey did actually seek any sexual healthcare on return home. However, due to time constraints and the anonymous nature of the survey this would not have been possible; although the use of a longitudinal study was utilised in the secondary study of the thesis, to be discussed later.

Only around a third of participants (34.1%) had received information on sexual health, alcohol or drugs whilst in Ibiza, despite their length of stay by the point of the survey averaging over ten weeks. Health information and literature distributed for travellers is aimed primarily at tourists visiting holiday resorts or backpacker destinations (see Appendix 5).

Health services in Ibiza do not provide specific services for sexual health or drug and alcohol

misuse for international travellers to the destination. With high levels of substance use, experimentation with new drugs and widespread sexual activity among casual workers, the availability of information on health risks, harm reduction and where to go for health advice and treatment should be considered essential; especially information that is tailored for casual workers. In addition, only 28.9% of casual workers had visited a doctor or hospital during their stay in Ibiza. Considering the length of stay of participants, and the levels of excessive drug and alcohol use and risky sexual behaviour, these figures are surprising. For example, despite high levels of unprotected sex in Ibiza (50.0% of participants), only 13.3% had received emergency contraception for themselves or their partner and only 10.2% had received a pregnancy test. The qualitative findings showed that only a third (28.9%) of casual workers had visited a hospital or doctor for sex, drug or alcohol related illness or injury. However, the ethnographic findings showed that the health services in San Antonio felt overrun by young British people visiting with such concerns. For that reason, it could be hypothesised that young casual workers are less likely than tourists to visit health clinics and receive healthcare.

While at home in the UK, young people will have greater access to harm reduction messages about sexual health, such as the risks of unprotected sex and sex with individuals not from their own country of residence. Authoritative figures such as parents and guardians, and peers such as friends may relay messages about sexual promiscuity and its connotations and stigmas. However, in Ibiza there is a clear lack of guidance or boundaries when it comes to sexual behaviour, and workers are existing in an environment where 'anything goes'. This is an example of where 'liminoid' behaviour is taking place as structures, responsibilities and rules are suspended over the time spent in Ibiza, also called 'anti-structure' (Turner, 1967, 1969). This is particularly risky as casual workers are creating their own rules and acceptable social norms. Previous studies have found that this type of attitude exists in tourists visiting

holiday resorts (e.g. Briggs et al., 2011a; Ragsdale, 2004). Individuals may have expectations to take part in sexual behaviour outside of the norm whilst in temporary holiday environments, such as visiting strip clubs (Briggs et al., 2011b; Hesse & Tutenges, 2011). Just like tourists, casual workers may have such expectations for their time in Ibiza but remain in holiday destinations for notably longer periods of time. Consequently, casual workers who are exposed to a boundary-less environment of sexual inhibition for a greater amount of time will be at a greater risk of encountering sexual health and social problems. This raises the question of when interventions should be targeted, and whether the presence of a regular or permanently fixed service, like a specialised sexual health version of Ibiza-24/7, would be more useful than just literature. However, this raises another question of who would fund this, and would casual workers be interested.

In Ibiza there are existing health services that offer basic care for tourists visiting the island for short periods of time. Health services are also in place for the registered Spanish residents of Ibiza that live on the island all year round. However, casual workers can be seen to be in healthcare limbo as the services do not stretch to accommodate their needs as they are neither short-term tourists nor residents. EU residents are typically issued European Health Insurance Cards (EHIC), which provides access to basic healthcare for free or at a reduced cost for those travelling within EU countries. Nevertheless, actual use of the card can be limited, as inclusion of particular treatments can vary per country. In nightlife orientated holiday destinations individuals may find themselves paying a high cost for healthcare as many illnesses and injuries are a result of alcohol and drug use, which is not covered by the EHIC under any circumstance. Of those casual workers who did visit a doctor or hospital, 62.5% of reported visits were not alcohol, sex or drug related. However, health service providers in Ibiza felt that the majority of visits to health centres by young British tourists and casual workers were predominately drug or alcohol related injuries or illness. This exemplifies

where consistency and validity of statistical findings need further in depth qualitative exploration. Private healthcare clinics were evidently over-run with intoxicated tourists every evening, many with serious conditions related to overdose of illicit substances. Similarly, the Centre Salud (health centre) in San Antonio reported that it did not have enough ambulances to deal with the number of drug and alcohol related incidents occurring on the streets of San Antonio involving young British tourists. Therefore, casual workers are clearly displaying different health seeking behaviours from those of regular tourists. This highlights a gap in research on the actual utilisation of such services, and individual perceptions of illness and injury related to drugs and alcohol.

Unlike non- working short-term holidaymakers, the majority of casual workers do not have disposable spending money, and therefore are often unable to justify paying for healthcare during their stay. Casual workers tend to spend a great deal of money in the first few weeks of being on the island, on the premise that in gaining employment they will be able to safely fund the rest of their stay. Nonetheless, jobs are competitive and wages are very low, leading to financial instability and bouts of unemployment. Visiting a public healthcare clinic for an alcohol, drug or sex related treatment could be charged at approximately 80 euros per visit (approx. £65). Similarly, private healthcare clinics are charging around 140 euros (approx. £120) just to be seen by a health practitioner. Examples of common health problems reported during the observational fieldwork by casual workers in Ibiza were abdominal pain, STDs and insomnia; all of which can be linked to individuals' excessive use of drugs and alcohol and their involvement in risky casual sex. Nevertheless, treatment of such ailments can be an unnecessary cost to casual workers who would rather wait to receive free treatments and testing at home in the UK; often displaying a nonchalant attitude about their immediate health. For that reason, casual workers were not seeking health care for these ailments whilst in Ibiza. Consequently, casual workers are increasingly accustomed to living with sometimes

severe health problems for extended periods of time. It could also be said that casual workers may not want to visit a doctor or hospital for fear that they may have to return home to the UK, or that they may not be able to drink alcohol or take drugs, which may inhibit their fun. Although there were no reports of any deaths within the casual worker population during the data collection period, it was clear that there were informants that were suffering from health problems that could be very serious. However, without further research figures around mortality rates of those working in holiday destinations are unknown.

Visiting a health practitioner is commonly a last resort when their symptoms become unbearable and they are forced to pay for treatment. Yet, casual workers' blasé attitude towards check-ups and poor knowledge of health ailments could lead to serious consequences, for example, in the rapid spread of STDs and even HIV. This is a high risk within a population that has regular sexual encounters with tourists, other casual workers, people from various nationalities and local residents. For that reason, casual workers are a critical target for sexual health intervention in particular.

As well as the cost of treatments, casual workers displayed a lack of trust in foreign health services. Discourse between workers about health care centred primarily on costs, but also on the inefficiency and mistrust of services they had encountered. Workers felt they had been 'ripped off' or that their illness and injuries were not treated effectively. Negative experiences were exacerbated and stories often spread quickly through worker networks, each taking on its own exaggerated narrative. This consequently reinforced their views of waiting to receive treatment back home in the UK. This means that the targeting of health advice and/or information must be directed in such a way that enables casual workers to seek and access healthcare sooner.

As a sub-population of tourists, casual workers become immersed into a culture of hedonism and thrill seeking behaviours that is often outside of their typical boundaries. Whilst away from authoritative figures at home, casual workers may become disinhibited and experimental activities such as drug taking and risky sexual behaviour gradually become part of their everyday lived experience (Eiser & Ford, 1995). In Ibiza, boundaries are being stretched and normal moral codes diminished, as casual workers live in a socially accepting environment where ‘anything goes’. With the length of time that is spent in the holiday resort, and the level of socialisation that is occurring, theoretically the behaviour of casual workers could also be compared to that of Bourdieu’s ‘habitus’; the set of dispositions that actors may have based on their social and economic place within their field (Bourdieu, 2000). In the case of casual workers, their behaviour is constrained by the amount of money they have and dictated by the social norm set by casual workers.

Scholars have previously commented that the behaviour of young tourists in holiday resorts can often be seen as an extension of their leisure time at home (Carr, 2002b; Khan et al., 2000). Nevertheless, casual workers stay in nightlife resorts is extended, and the time spent in hedonistic drug influenced environments like Ibiza can serve to facilitate the development of behaviours above and beyond those undertaken at home (Briggs et al., 2011b). Such behaviour is then normalised into the everyday social norms and values of the individual. The behaviour of casual workers followed a different pattern from non-working tourists as they were in the holiday environment for increased lengths of time, allowing for further development and change within individual behaviours. This raises the question of the extent to which these new social norms and values are internalised and the level to which they become normalised to the point of no return.

As previously highlighted, theoretical understandings of ‘liminality’ (e.g. Thomas, 2005, Wickens & Sonmez, 2007) have been applied to tourism. However, there is a separation

between *liminal* and *liminoid* behaviours, with the latter describing voluntary behaviour and the former describing obligatory actions (Bosley, 2009). For that reason, casual worker's behaviours can be described as 'liminoid' as reflected in the temporary behaviours and actions of individuals. Yet what may be of further interest is the period described as 'post-liminoid' (Graburn, 1989); whereby individuals may return to their 'ordinary' state when returning home after a period spent in a new environment. Little is known about the effect that taking part in such behaviours over a lengthy period of time may have on people's moral boundaries and norms at home, and if such behaviours may continue (hence, the inclusion of a longitudinal pre and post-holiday study, to be discussed in Chapter 3). Nevertheless, becoming a casual worker can be seen as a full rite of passage in itself (Van Gennep, 1960) as individuals enter a stage of 'separation' as they leave their home and enter the holiday resort environment; then they are in a transitional 'liminoid' state without structure or status; then to be 'reincorporated' into a casual worker society with its own set of norms, morals and social codes. Ultimately, the individual is changed and shaped by their experience over the summer season. However, in terms of relating this theoretical understanding of risk to a public health framework what is then important is to see what effect this transitional period on people's attitudes and behaviours towards risk activities like drug use and risky casual sex, especially when they return to their homes in the UK.

It is very clear from the ethnographic findings that situational factors are at play that effect individual's participation in risk behaviours. For example, young people are consuming large quantities of drugs as a means to stay awake to visit nightclubs and parties, whilst managing to sustain employment. Casual workers are also drinking excessive amounts of alcohol as this is supplied to them within their workplace. Such factors may differ from those found at home, therefore individuals may become a 'different person' whilst working in San Antonio (Maticka-Tynedale et al., 2003; Milhaussen, 2007). Urielly & Belhassen (2005) describe such

behaviours as ‘marginal’ and ‘deviant’; yet what they emphasise is that these terms may be used instead of ‘criminal’ as although activities such as drug dealing may be a morally divisive topic, in this environment it is seen as socially legitimate/decriminalised.

There may be many obvious similarities drawn between casual workers and non-working tourists, such as drinking, attending nightclubs and socialising on the beach. Moreover, such working travellers have previously been recognised as a type of tourist within the literature (Briggs, 2013; O’Reilly, 2000; Rice, 2010; Uriely, 2001). However, casual workers in this study were striving to dissociate themselves from being classed as tourists by pushing themselves to limits outside of typical holiday parameters. Part of this disassociation came in the form of initiation acts to welcome first time workers into their group, such as ‘dropping their first pill’ or going to a worker party.

Similarly, casual workers are not always able to take part in tourist-like behaviours because of the long hours that they work, and the anti-social hours in which they socialise. After all, the idea of a holiday is to at least fit in a little relaxation, and escape from the responsibilities of jobs at home. Yet, casual workers are willingly putting themselves in these out-of-the-ordinary situations to differentiate themselves. Nevertheless, there are populations of workers that began their time in Ibiza as tourists and decided to stay, and this is where many boundaries become blurred in defining the typology of the ‘casual worker’. Many workers arrive on the island and fail to find employment, spending their time taking part in touristic exploits such as sunbathing and partying. However, this unemployed population are still keen to distinguish themselves as ‘workers’ and not ‘tourists’, for example only socialising with other workers/jobseekers. The thesis introduced the idea of the ‘tourist worker continuum’ in chapter 1, identifying that within literature there is a difficulty to find a unified definition of a person who works in a tourist destination. Nonetheless, although casual workers in Ibiza are distinguishing themselves from tourists in practice, in theory they still come under the broad

umbrella term of ‘tourist’. Therefore I would posit that casual workers, as described in this study would fit best under the definition of ‘working holiday-makers’ as outlined by Cohen (1973) and Uriely (2001) for the following reasons:-

- Working in Ibiza is not necessarily to make money to take home, it is to make enough money to stay on the island.
- Most casual workers do not see their jobs as a career, it is more of a recreational activity (especially as they can drink alcohol on the job)
- Working is typically only for a short period over the summer months
- Workers partake in tourist exploits such as partying, sunbathing and drinking
- Workers may not always be registered as such, or may be unemployed, therefore cannot essentially be classed as a ‘travelling worker’ or ‘migrant worker’

As previously identified, although casual workers may be adamant that they are ‘workers’ and not ‘tourists’, in theory the term tourist is so broad and encapsulating that it does in fact include this type of working population. Nevertheless, the fact that casual workers differ from short-term non-working tourists in the length of time that they spend in holiday resorts, and the level to which they may take part in risk behaviours, this could potentially leave them in healthcare limbo in terms of services that accommodate their needs. The value in defining casual workers as ‘working holiday-makers’ may lie in the fact that such a group can then be distinguished from other types of tourists and therefore studied in different ways, allowing for consistency within literature. Yet, even within one casual worker population there are so many variations of this type, for example, holiday reps working for large holiday companies, registered bar workers, unregistered ticket sellers, and the ‘unemployed’ seeking work.

Therefore, although the majority of casual workers involved in this study may fit within the ‘working holiday-maker’ definition provided by Uriely (2001) and Cohen (1973), there are

some that would be seen as ‘migrant workers’ or ‘travelling workers’, such as holiday reps. This is because such groups are registered to work on the island, do tend see their job as a career, and work to make money to take home, moreover their work is less ‘casual’. This highlights where boundaries will continue to be blurred within complex environments with a multitude of different tourist/worker types, and for that reason there may not always be value in laying concrete boundaries.

At a basic level, casual workers could be seen to set the precedence for behaviour in holiday resorts, both influencing the activities of tourists (e.g. Tutenges, 2013) and maintaining risk environments. For that reason, if casual workers felt an increased responsibility for their individual health and safety, for example taking fewer drugs, this could influence the behaviour of their peers. Previous studies have identified that casual workers may be best placed to deliver health messages to tourists (e.g. Hughes & Bellis, 2006), yet it has to be questioned how much more extreme their behaviour is compared to tourists, so how capable are they of setting a good example. Casual workers have been can often see themselves as a ‘cut above’ tourists (Briggs, 2013, O’Reilly, 2000) as they are the ones who get to stay in holiday destinations for longer periods of time therefore see themselves as ‘living the dream’ (Briggs, 2013: 91).

‘The tourists look up on the casual workers and envy them because they have this access to the party lifestyle on tap, while the casual workers look down on the tourists because they are only here for a short period of time and don’t have the balls to do what they are doing’

(Briggs, 2013:92)

However, such statements cannot be upheld without collecting data from tourists about their attitudes towards casual workers; without such voices from tourists themselves it is unknown

if this is really the case. Little is known about the relationships of power between casual workers and tourists, and this thesis has only touched upon the surface of interactions between both populations. Therefore, it cannot be assumed that tourists would see casual workers as their peers when delivering health messages, or when setting examples of behaviour. Although it has been shown that casual workers may be instrumental when advising tourists about drug use or coercing them into their bars and nightclubs, it cannot be assumed that tourists are not exercising their own level of agency and choice in these situations. The literature review identified that holiday reps in particular are a group that can exercise control and power over tourists on package holidays, for example in taking part in drinking games and activities (Andrews, 2005; Tutenges, 2013). However, the casual workers in this study were mainly working in bars and nightclubs, or ticket selling, external to any tour operator activity, therefore their level of influence on tourists is questionable.

4.8.1. Conclusion

The purpose of the Ibiza casual workers study was to provide a holistic exploration of risk behaviours and the health consequences of such; hence the use of both quantitative and qualitative ethnographic methods (fulfilling objective [c]). The study aimed not only to measure and describe the risk and health treatment seeking behaviours of casual workers in an international resort, but also to understand the behavioural norms and experiences that may contribute to such risk behaviours. As identified in the literature review, the majority of existing studies in this area has been quantitative, and has only touched upon casual workers as a tourist type. Yet what this study provides is a basis for casual workers not only to be defined as a separate population from regular tourists, but also as one of the most high-risk sub-groups.

The study contributes towards the aims of the thesis in exploring a particular type of ‘tourist’ in what could be classed as one of the most notoriously hedonistic resorts in the world; a resort in which drug use, excessive alcohol use and non-stop partying is inherent. One of the most interesting findings, which relates to the second aims of the thesis, was the identification of different types of health services existing and even competing within one holiday arena. A particular worry is that within private healthcare clinics the focus may be taken away from providing quality healthcare, with making a profit their main priority. This perhaps identifies a wider problem within healthcare delivery and a barrier to providing quality health care or health messages that are free or low cost. This means that there is not only a need for tailored healthcare for tourist groups, but also a need to find a way to reach tourist that are vulnerable to the costs of healthcare.

It is clear that health literature is needed that is tailored to casual workers in particular, and takes into account their extended stay in nightlife-related holiday resorts. Stakeholders from both home and host countries, such as health and tourism authorities, must be consulted to develop adequate information for dissemination. As well as the dissemination of materials on the ground, information must be targeted at young people who may potentially work in destinations like Ibiza using relevant media tools, such as websites and online forums. Casual workers need to be better equipped to work in such destinations, therefore educational strategies must be implemented that cover such issues as access to healthcare, nutrition, criminality and legal issues, and rights and safety within workplaces. Services have the potential to be implemented that provide cheap or free healthcare for populations. Nonetheless, questions are raised over who has the social and financial responsibility to provide such services.

San Antonio, Ibiza could be seen as an extreme case, yet a study like this can potentially be used as a benchmark for investigations into casual workers in other resorts; in particular, in

using qualitative methods such as ethnography to complement numerical data and improve the depth of the research. Although casual workers may be seen as a niche group to study, without visiting a resort like San Antonio, it may be difficult for others to fully comprehend the affect that such populations have on the dynamics of risk behaviours and the social norms that are set for tourists. Moreover, we must be able to understand how well workers are placed to set an example to tourists and set social and moral standards that could contribute to harm reduction. It is clear that casual workers have few options when it comes to accessible healthcare in Ibiza. Therefore, if we can direct health messages and services that are applicable and accessible to casual workers, this could in turn decrease their involvement in risk behaviours and increase their health seeking behaviours. In understanding why their behaviour occurs in the first place, this is one step forward in providing appropriate healthcare at a grassroots level.

Chapter 5: The longitudinal holidaymakers' study

5.1. Introduction

The aim of the thesis was to explore the risk behaviours of different types of tourists in different contexts, and to identify gaps in health service provision for holidaymakers. To achieve this it is not only important to look at specific groups, such as casual workers, but also general populations of holidaymakers visiting different destinations. To capture a larger amount of data quantitative methods are often the most appropriate, in particular short surveys. The previous study of Ibiza casual workers raised a number of questions about how risk behaviour on holiday can potentially have an effect on tourist groups when they return home. For example, the continuation of drug use as a result of recruitment to use on holiday, or continuing promiscuous sexual relationships in the UK. Therefore, it was important to explore methods that allowed for measurement of behaviour pre and post travel, to compare change in individuals. The objective and research question was formed:

Objective (d): *Trial a method of identifying the impact of holiday risk taking behaviours on young people's longer terms risk taking by implementing a three-stage longitudinal quantitative study among general holidaymakers to measure risk behaviours before, during and after the holiday;*

RQ3: *what changes in levels of individual's risk and health seeking behaviours take place pre and post-travel?*

Longitudinal studies are an effective way of measuring changes that may occur over specific periods of time, such as behaviours or attitudes of large and small populations. For example, standardised and continual longitudinal surveillance studies have been commonly used in the UK to measure changes in national populations (e.g. 'The Millennium Cohort Study' - Smith & Joshi, 2002; 'The North West England Longitudinal Study' - Parker et al., 2002).

Internationally, longitudinal studies have been used in public health research to measure

changes in levels of alcohol use (e.g. Hanewinkel & Sargent, 2009; Young et al., 2007), drug use (e.g. Parker et al., 2002, Newbury- Birch et al., 2002; Rorhbach et al., 2002) and risky sexual behaviour (e.g. Huebner et al., 2004; Zablotska et al., 2006) in young people and adults, over given periods of time. For example, in a study of young people in the West of Scotland, changes in anti-social behaviour and alcohol misuse were measured at significant age stages (11, 13 and 15 years old). The study found that anti-social behaviour at each stage was a predisposition and cause for alcohol misuse, with increasing levels of alcohol use as the age of participants increased (Young et al., 2007).

In the context of individuals in holiday resorts, there are very few studies that have adopted this method of continual measurement. Young people in particular have been highlighted as an at-risk group that may actively seek to take part in behaviours outside of the norm whilst in a holiday environment (e.g. Elliott et al., 1998; Ragsdale et al., 2006). This may consequently result in the continued involvement in risk behaviours on return home to countries of residence. Previous studies have measured behavioural or attitudinal changes, typically over two significant stages using pre-holiday, during holiday or post-holiday surveys (e.g. Apostolopoulos et al., 2002; Elliott et al., 1998; Klunge-de Luze et al., 2014; Vivancos et al., 2010). A study of young people travelling from Scotland measured their sexual and substance use behaviours immediately after their holiday and again using the same questionnaire at a holiday reunion dance event back in Scotland two months after the holiday. Findings showed that participants consumed alcohol a mean of 3.2 days a week whilst on holiday, whereas on return back home to Scotland, participants consumed alcohol on a mean of only 1.6 days a week. Similarly, changes in sexual behaviour were recorded, with 50% reporting that they had sex whilst on holiday, compared to 67% who reported having had sex at home (Elliott et al., 1998). However, this does not give an overall picture of changes that occur as a consequence of the holiday as pre-holiday behaviour was not measured.

A pre-trip survey was used in a study of young American university students attending spring break (Apostolopoulos et al., 2002). The survey asked participants about their previous substance use and sexual behaviours, but also about their expectations and intentions for their upcoming trip. On immediate return from spring break, students were asked about their actual substance use and sexual behaviour during their stay. The study measured the effect that expectations and influences such as peers and situational factors influenced their behaviour. However, follow-up data was not collected for the post-holiday period.

In a study of young people visiting Ibiza to take part in casual work, a single survey was used at the end of their stay to measure their sexual behaviour before their time spent in Ibiza and during their time abroad (Hughes & Bellis, 2004). The questionnaire measured the number of sexual partners that individuals had had in the previous six months before arriving in Ibiza, and the number of sexual partners whilst in Ibiza working. Although the findings did not show any significant changes between sexual behaviours pre- trip or during the trip to Ibiza, the use of such comparative terms of measurement should not be discounted for future research. Such comparisons can serve to monitor behaviour change in tourists over significant periods of time. Similarly, measurement of substance use in Ibiza (compared with previous UK use) has highlighted the risks of potential recruitment and relapse into drug use after significant periods spent abroad in holiday settings (Bellis et al., 2003, Hughes & Bellis, 2004).

A study of young British students over a summer break period, measured foreign travel as a risk factor for increased casual sex and the acquisition of sexually transmitted diseases (Vivancos et al., 2010). The study involved a baseline online survey distributed to students at the beginning of the summer, and then one sent at the end of summer. The study captured those who did and did not go on holiday. The questionnaire asked participants about their drug and alcohol intake, sexual behaviour (including number of sexual partners) and lifetime

diagnosis of STDs. Comparisons were made between the two surveys. This method proved successful in gaining around 500 participants that completed both parts of the online survey.

In introducing a range of longitudinal and iterative studies that have been used on young travellers to holiday destinations, it is clear that this can be an effective and robust form of measurement of behavioural change (Apostolopoulos et al., 2002; Elliott et al., 1998; Klunge-de Luze et al., 2014; Vivancos et al., 2010). In terms of the previous findings from the Ibiza casual workers chapters it is clear that there are a number of factors that require such measurement. Findings from chapter 4 of the thesis have shown that of those who used illegal drugs in Ibiza, 56.2% had used a drug that they had never previously used or not used in the previous 12 months. This level of recruitment to drug use in holiday destinations requires monitoring due to the potential for recruited users to continue using substances on return home. Such use could contribute to cultures of recreational drug use breeding amongst networks in home countries as a result of behaviours experienced on holiday. Similarly, a high level of risky sexual behaviour amongst casual workers was found in chapter 4, such as unprotected sex and sex with multiple partners. Participants had a mean of 0.82 sexual partners per fortnight in Ibiza compared with 0.14 in the UK. Again, such behaviours that are normalised in holiday destinations have the potential to breed new norms and values that continue at home.

As highlighted, previous studies on young holidaymakers and casual workers have yet to use three stage longitudinal methods; looking at behaviour pre-holiday, during the holiday and post-holiday. In applying such methods this would provide a valuable picture of how time spent on holiday can change the behavioural patterns of individuals as they resume every-day life at home.

5.2. Methods

The aim of the longitudinal holidaymakers study was to capture individuals' behaviour over three significant stages; before, during and after time spent abroad travelling or on holiday. The study objective was to measure substance use, sexual activity and the utilisation of health services at each stage to enable a comparison of change or consistency. The study incorporated the use of a series of short questionnaires with repeated questions at each stage. In contrast to cross sectional studies, this potentially allows the identification of factors that may affect behaviour at each stage of the sequence. This can be vital for the potential implementation of intervention strategies both abroad and in the UK. The survey data collection took place over a one year period from January 2011 to January 2012; the one year period was used to capture data on those going on holiday from April through to October; and also to leave enough time to send reminders to participants.

5.2.1. Quantitative online questionnaires

Three questionnaires were developed which used a similar structure to the survey used in the study of casual workers in Ibiza and to surveys previously used with young holidaymakers (e.g. Bellis et al., 2003; Hughes & Bellis, 2006) as this proved to be an effective and transferable layout. An online survey tool (www.surveymonkey.com) was selected to ease the delivery of questionnaires to participants by providing a simple website link, which could be attached to an email or flyer. This also allowed for the collection of data directly into a confidential online database. The advantages of using such software is easier access to participants in distant locations, and the ability to reach people who may be difficult to reach face to face, which means that the time and effort of the researcher can be greatly reduced (Wright 2005). It can also mean that participants may be more likely to fill in information about sensitive issues as they may be in their own private space at home (Alessi & Martin,

2010). The questionnaires were developed to be quantitative and short, using a tick-box system to minimise the amount of time a participant spent filling in each survey; with the intention of minimising the drop-out levels at each stage.

To capture individuals' behaviour at each stage, the first questionnaire was distributed to participants before their holiday and examined their behaviour in the previous three months.

The second was sent to participants on the date they returned from their holiday, and examined their behaviour during their holiday. The third was sent out three months after their holiday, and examined their behaviour over this three-month period since returning home from holiday. This allowed for a significant and comparable period where changes in behaviour could be measured, yet was a small enough time frame to keep individuals interested in completing all three surveys in succession.

The first questionnaire before the participants' holiday used the following types of questions (see Appendix 6 for full survey):

- Demographics: gender, age, employment status
- Holiday details: destination, dates leaving and returning, reason for destination choice, number of males and females the individual was travelling with, type of travel companions
- Participants' use of substances over the previous three month period in the UK
- Participants' sexual behaviour over the previous three month period in the UK
- Participants' use of health services over the previous three month period in the UK
- Whether participants had been involved in a fight, injured themselves, or thought they might have been pregnant (and other such questions) over the previous three month period in the UK

The second questionnaire, distributed just after each participants' holiday, used similar questions with the time frame adjusted to reflect the holiday period (see Appendix 7 for full survey), covering:

- Participants' use of substances over the time spent on holiday
- Participants' sexual behaviour over the time spent on holiday
- Participants' use of health services over the time spent on holiday
- Whether participants had been involved in a fight, injured themselves, or thought they might have been pregnant (and other such questions) over the time spent on holiday

The third questionnaire distributed to participants three months after returning from their holiday repeated the same questions measuring (see Appendix 8 for full survey):

- Participants' use of substances in the three month period after their holiday
- Participants' sexual behaviour in the three month period after their holiday
- Participants' use of health services in the three month period after their holiday
- Whether participants had been involved in a fight, injured themselves, or thought they might have been pregnant (and other such questions) in the three month period after their holiday

The questionnaires were initially tested for usability with a small pilot group of 10 participants aged 16-35 from the North West of England. The pilot group was recruited using a social networking site and a snowballing technique whereby pilot participants were given a link to the first online survey two weeks before their holiday. Their email address was then used to send them the follow up survey just after their holiday, and then the final survey was sent to them two weeks after their holiday. This allowed for the longitudinal online survey

technique to be evaluated before being implemented over a longer time frame. For each survey participants were asked to give their email address and their mother's maiden name, enabling their data to be linked across stages. Ethical approval for the study was given by the Liverpool John Moores University Research Ethics Committee (see Appendix 9).

5.2.2. Recruitment

The target sample for the questionnaire series was British individuals aged 16-35 who were going on holiday or away for a short period of travel in summer 2011. An advertisement flyer was produced in both a paper version and an online version providing details of the study and the website link in which participants could access the first survey (see Appendix 10). The paper version of the flyer was pinned to Liverpool John Moores University (LJMU) noticeboards within library resource centres and within the Centre for Public Health, LJMU. The online version of the flyer was sent via email to LJMU students using a mail-out system through each faculty. The flyer was also shared on the social networking site Facebook using a snowballing technique of sharing the flyer with friends and acquaintances. Snowball sampling is often used to reach difficult to reach individuals and communities, especially in public health related studies, and allows participants to identify people who may also be interested in taking part in a study, and so on (Sadler et al., 2010). This can be particularly helpful when trying to identify participants for studies that may be on such topics as drug use and sexual behaviour (Atkinson & Flint, 2001). A convenience sampling technique was also utilised by using the paper flyer in areas within the university where the target age population would exist. Using a convenience sample for this part of the recruitment process was helpful in being able to access a large amount of students that were within the age range of 16-35 years old and who might be travelling on holiday during their summer time break. This method was chosen due to the ease of being able to access potential participants on the LJMU campus, but also in being able to cut down the costs of recruitment (Marshall, 1996).

Convenience sampling has been previously used in studies of young people travelling to holiday destinations in order to gather a sample based on criteria such as the type of holiday they are going on, their gender or relationship status (e.g. Bellis et al., 2007; Ragsdale et al., 2006).

Once the participant accessed the online questionnaire using the web-link, an explanation of the study was provided and participants were informed that they would be required to provide their email address and mother's maiden name to enable the researcher to link all three surveys. Although participants were informed that these identification details would remain confidential, some individuals may have felt that this system compromised their anonymity and therefore chose not to give this information. In turn, this meant that the second and third surveys could not be distributed to these participants (n=4).

Participants were informed of their anonymity and their right to withdraw without reason at any point of the study. Consent was gained electronically by completion of the first survey online. All participants were informed that if they needed any assistance or would like to know any further information about the study, to contact the researcher immediately.

After completion of the first survey, participants' email addresses and dates of travel were recorded on a password encrypted Excel database. This enabled the monitoring of the dates on which the second and third surveys would be sent to each participant. The second survey web-link was then sent via email to each participant at the required date after their holiday, followed by the third and final survey three months later.

All online surveys throughout the study were automatically saved into a password protected database on the website (www.surveymonkey.com) and were only accessible to the researcher.

5.2.3. Analysis of findings

The data gathered from the series of questionnaires was originally entered into three separate SPSS databases for each stage of the study, and then merged into one large database linking the data of each individual participant. Data analysis included Chi-squared, including Pearson's, McNemar and Cochran's Q tests (Field, 2000; Gray & Kinnear, 2011). The inclusion criteria were that participants were aged between 16-35 and were going on holiday or a short period of travel. All participants who completed the initial first survey met these criteria. However, seven participants accessed the first online questionnaire using the web-link but failed to complete any of the questions, and therefore were not included. Reminder emails were sent to each participant to prompt them to complete each stage of the survey throughout the process. Nevertheless, there was a notable drop-out rate of participants from the first study (n=161), to the second (n=69) and third (n=47) studies.

5.3. Findings

5.3.1. Drop-out rates

The survey measured participants' behaviours in the three months before their holiday, during their holiday period (typically 7-14 days), and during the three months after they returned from their holiday. For the purpose of the findings, the stages will be described as survey 1 (before holiday), 2 (during holiday) and 3 (after holiday).

Table 7: Demographics of participants that did or did not complete Surveys 2 and 3

		Survey1 n=161	Survey 2 n=69				Survey 3 n=47			
			Completed				Completed			
			Yes	No	<i>X</i> ²	<i>P</i>	Yes	No	<i>X</i> ²	<i>P</i>
Gender	Male	24.8	23.2	26.1	0.177	0.674	21.3	27.3	0.302	0.582
	Female	75.2	76.8	73.9			78.7	72.7		
Age Group	18-20	33.5	24.6	40.2	4.353	0.113	23.4	27.3	0.335	0.846
	21-25	39.1	43.5	35.9			42.6	45.5		
	26-35	27.3	31.9	23.9			34.0	27.3		
Employment status	Full time	34.2	50.7	21.7	14.74	0.001	51.1	50.0	0.12	0.942
	Part time	8.1	5.8	9.8			6.4	4.5		
	Student	57.1	43.5	68.5			42.6	45.5		
	Unemployed	0.6	0	0			0	0		
Holiday Type	Europe beach holiday	50.6	52.2	49.5	1.606	0.658	53.2	50.0	2.254	0.521
	Europe other	26.3	26.1	26.4			25.5	27.3		
	Non-Europe beach holiday	8.1	10.1	6.6			12.8	4.5		
	Non-Europe other	15.0	11.6	17.6			8.5	18.2		
Length of Stay	1-6 days	15.4	18.8	12.6	2.494	0.287	21.3	13.6	5.519	0.063
	7-14 days	68.6	69.6	67.8			61.7	86.4		
	15+ days	16.0	11.6	69.6			17.0	0		
Why chose holiday	Weather	57.8	63.8	53.3	1.784	0.182	63.8	63.6	0	0.988
	Nightlife	36.6	34.8	38.0	0.181	0.671	34.0	36.4	0.036	0.85
	Family/friends	28.6	27.5	29.3	0.063	0.801	23.4	36.4	1.261	0.261
	Sex	5.0	1.4	7.6	3.168	0.075	2.1	0	0.475	0.491
	Drugs	5.0	1.4	7.6	3.168	0.075	2.1	0	0.475	0.491
	Culture ⁶	43.5	44.9	42.4	0.103	0.748	42.6	50.0	0.336	0.562
	Music	17.4	14.5	19.6	0.706	0.401	12.8	18.2	0.355	0.551
	Cost	26.1	33.3	20.7	3.288	0.07	29.8	40.9	0.834	0.361

⁶ **Culture**- Concerned with history, art architecture (for example museums or landmarks)

Participant drop- out rates for completion of survey 2 and survey 3 are presented in Table 7. Due to the high proportion of participants dropping out at survey 2 and 3, the remainder of the analysis focuses primarily on the participants who fully completed all three surveys (n=47). There were no differences in gender at each stage of the survey; however, the dropout rates showed that those who were employed were more likely to continue with the surveys.

5.3.2. Characteristics

The following findings represent only the participants who had completed all three stages of the survey (n=47).

Most participants were female (78.7%) and the average age was 23.7 years. The majority were students (42.6%) or employed full time (51.1%). Most participants (91.5%) were travelling for the purpose of a holiday and just over half went on a European beach holiday (53.2%). The average length of stay was 14.2 days. Around half of participants were travelling with friends (48.9%) or with a sexual partner or spouse (53.3%) (some were travelling with both). The majority reported that they were choosing to travel for the weather (63.8%), nightlife (34.0%) and culture (42.6%).

Only a small percentage of participants were travelling for sex or drugs (2.1%). McNemar analysis was used to measure changes in bar and nightclub attendance at stages 1, 2, and 3, with which increases were seen whilst participants were on holiday compared to previously at home in the UK. Of the 47 participants, 15.2% reported visiting bars two or more days a week at stage 1, increasing to 83.0% at stage 2 (See Table 9). Only 18.2% reported visiting a nightclub two or more times a week in the UK, compared to 36.2% that visited two or more times a week whilst on holiday.

Table 8: Demographics of participants that completed all three surveys by gender

		All		Male		Female		X ²	P
		n=47	%	n=10	%	n=37	%		
Age Group	18-20	11	23.4	1	10.0	10	27.0		
	21-25	20	42.6	7	70.0	13	35.1		
	26-35	16	34.0	2	20.0	14	37.8	3.96	0.14
Reason for travel	Holiday	43	91.5	9	90.0	34	91.9		
	Work	1	2.1	0	0	1	2.7		
	Travel	3	6.4	1	10.0	2	5.4	0.53	0.77
Employment	Employed full time	24	51.1	6	60.0	18	48.6		
	Employed part time	3	6.4	0	0	3	8.1		
	Student	20	42.6	4	40.0	16	43.2	1.03	0.6
Travelling with	Friends	22	48.9	3	33.3	19	52.8	1.09	0.3
	Family	6	13.3	1	11.1	5	13.9	0.05	0.83
	Partner/Spouse	24	53.3	7	77.8	17	47.2	2.7	0.1
Why chose destination	Weather	30	63.8	5	50.0	25	67.6	1.05	0.31
	Nightlife	16	34.0	3	30.0	13	35.1	0.09	0.76
	Family/friends	11	23.4	4	40.0	7	18.9	1.95	0.16
	Sex	1	2.1	0	0	1	2.7	0.28	0.6
	Drugs	1	2.1	1	10.0	0	0	3.78	0.05
	Culture	20	42.6	5	50.0	15	40.5	0.29	0.59
	Music	6	12.8	2	20.0	4	10.8	0.6	0.44
	Cost	14	29.8	4	40.0	10	27.0	0.63	0.43
Length of stay	1-6 days	10	21.3	0	0	10	27.0		
	7-14 days	29	61.7	7	70.0	22	59.5		
	15 and over days	8	17.9	3	30.0	5	13.5	4.1	0.13

Table 9: Participants that visited bars and nightclubs 2 or more times a week at Survey

1 (Home, UK) and 2 (Holiday)

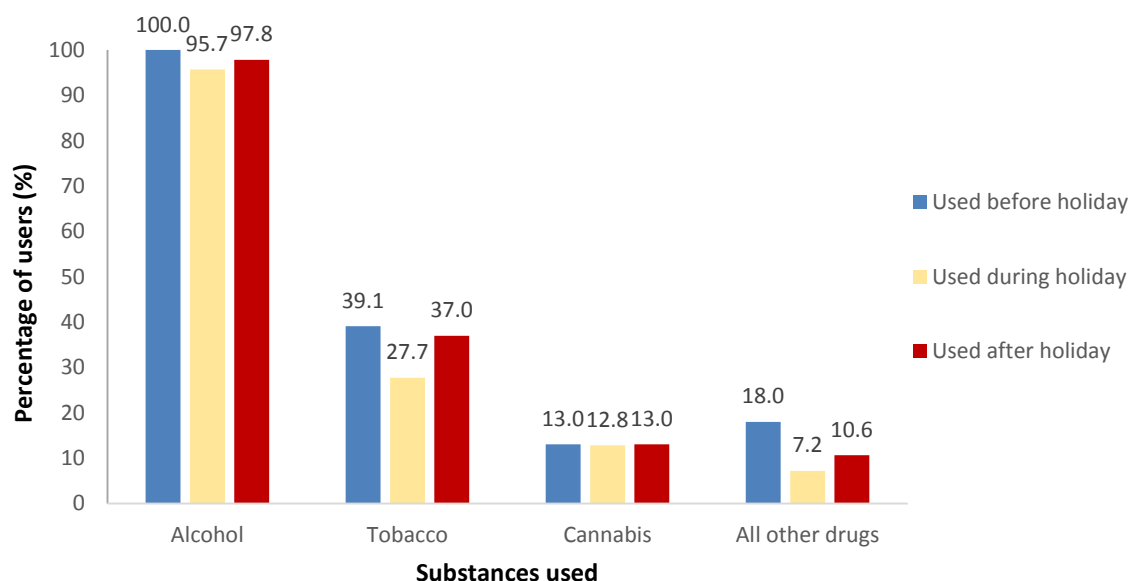
		Survey 1		Survey 2		X ² between surveys
		%	n	%	n	
Visited a bar 2 or more times a week	Yes	15.2	7	83.0	39	
	No	84.8	39	17.0	8	<0.001
Visited a nightclub 2 or more times a week	Yes	18.2	8	36.2	17	
	No	81.8	36	63.8	30	0.118

5.3.3. Substance use

The survey asked participants about their substance use before their holiday, during their holiday and after their holiday, allowing for a comparison of behaviours at each stage. The substances were listed as alcohol, tobacco, cannabis, cocaine, ecstasy, amphetamines, ketamine and gammahydroxybutyrate (GHB). Each survey measured use on a weekly scale.

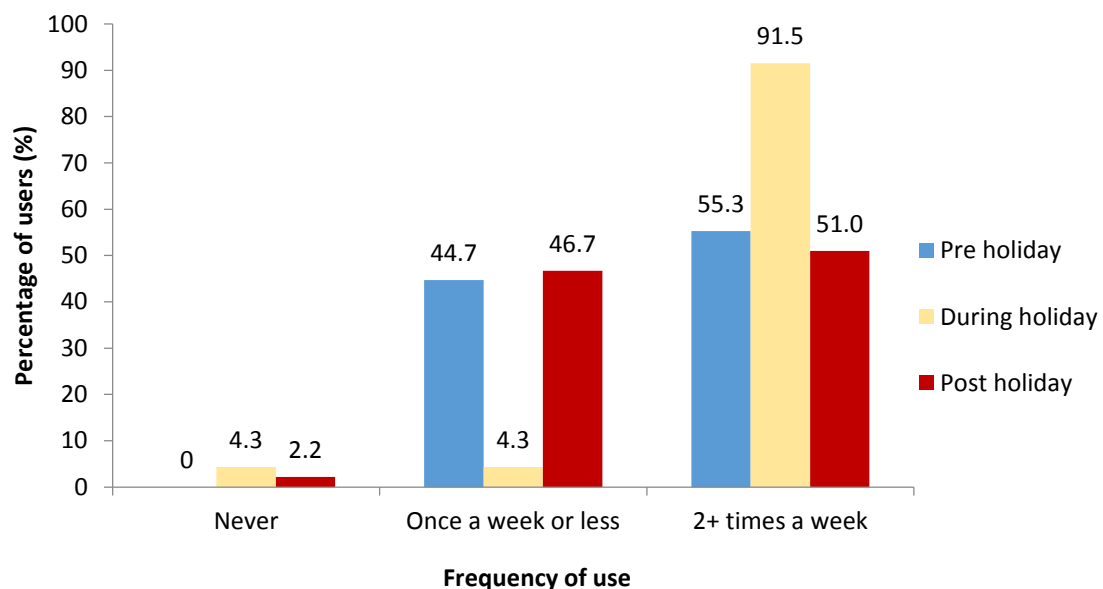
Figure 5 shows the percentage of participants that reported substance use at each stage. The vast majority used alcohol at all three stages of the survey (100%, 95.7%, 97.8%), around a third of participants used tobacco (39.1%, 27.7%, 37.0%) and around one tenth use cannabis (13.0%, 12.8%, 13.0%). Only a very small number of participants had used cocaine, ecstasy, amphetamines and GHB at any stage, and therefore these substances were grouped into one category called ‘all other drugs’ (see Figure 6).

Figure 6: Percentage of substance users at each stage of survey of those who completed all three surveys



Around one fifth (18.0%) of participants had used at least one of these illegal substances before their holiday, whilst only 7.2% used whilst on holiday. On return from holiday, there was a small drop in the proportion of participants reporting substance use compared with before the holiday period, with only 10.6% using illegal substances in the 3 months after their holiday. Only ten participants reported using illicit substances at stage 1 of the survey; half were students (50%) and half were employed full time (50%). Only six participants reported using illicit substances at all three stages of the investigation, thus meaningful analysis of changes in frequency of use was not possible. There were no differences in age group or gender for use of substances at all three stages.

Figure 7: Frequency of alcohol use per week pre-holiday, during holiday and post-holiday



The survey recorded changes in frequency of use of all substances before during and after the holiday period. Increases in the frequency of alcohol use in particular were notable during the

holiday period, with 55.3% using alcohol 2 or more times a week at stage 1, 91.5% at stage 2 and 51.1% at stage 3 (see Figure 7).

There were minimal changes in the frequency of tobacco use between the three stages of the survey, with 26.1% using two or more times a week at stage 1, 23.4% at stage 2 and 19.6% at stage 3. There were no significant differences between the frequency of use of cannabis or any other illegal substances due to low numbers of users in all locations. With such low numbers no meaningful data could be extrapolated about recruitment to drug use or polydrug use.

5.3.4. Sexual behaviour

The study asked participants about their sexual behaviour before their holiday, during their holiday and after their holiday. Participants were asked at each stage if they had a sexual partner or spouse, and how many males and females had they had sex with. Participants were then asked with how many of their sexual partners did they use a condom. If they had unprotected sex, they were then asked if they had been under the influence of alcohol or drugs at the time. Similarly, participants were asked if they had sex at any stage that they had later regretted and again if this had been under the influence of alcohol or drugs. For the purpose of this study the survey used measurements of condom use, other contraception use and non-contraception use to distinguish unprotected sex.

Of participants that completed all three stages of the survey (n=47), 93.6% reported having had sex in the 3 months before their holiday, 63.8% reported having sex during their holiday, and 91.5% reported having sex in the 3 months after their holiday. Participants reported a mean number of 0.09 partners per week before their holiday, 0.53 partners per week during their holiday and 0.09 partners per week since returning from their holiday.

Table 10: Sexual behaviour of all participants at each stage of the survey of those who had completed all three surveys

n=47		Pre-Holiday 1 (%)	n	During Holiday 2 (%)	n	Post-Holiday 3 (%)	n	P
Sexual partner/spouse	Yes	68.1	32	66.0	31	78.7	37	0.45
	No	31.9	15	34.0	16	21.3	10	
Had sex	Yes	93.6	44	63.8	30	91.5	43	<0.001
	No	6.4	3	36.2	17	8.5	4	
Had multiple sexual partners	Yes	14.9	7	6.4	3	17.0	8	0.269
	No	85.1	40	93.6	44	83.0	39	
Had unprotected sex	Yes	7.3	3	27.6	8	23.8	10	0.197
	No	92.7	38	72.4	21	76.2	32	
Had sex that later regretted	Yes	7.0	3	6.7	2	4.7	2	0.779
	No	93.0	40	93.3	28	95.3	41	

Just over half (59.6%) of participants reported having had sex in all three surveys (n=28). Of those who reported having had sex in each survey, 42.9% reported an instance of unprotected sex and 25.0% reported having had multiple sexual partners throughout the entire study period. Almost two thirds (61.7%) of participants had a sexual partner or spouse throughout the entire investigation period. Of participants who reported having had sex in each survey (see Table 10), 7.3% had unprotected sex before their holiday, 27.6% during their holiday and 23.8% after their holiday. A small number of participants who had sex at each stage, reported having had sex that they later regretted, before (7.0%), during (6.7%) and after (4.7%) their holiday. Of participants that reported having had sex at each stage, 14.9% reported having had multiple sexual partners before their holiday, 6.4% during their holiday, and 17.0% after their holiday. There were no significant differences in the proportion of participants having had unprotected or regrettable sex at each stage, however there were significant differences in the proportion of people that had sex at each stage (<0.001).

5.3.5. Substance use and sexual behaviour

Participants' sexual behaviour was measured based on their substance use using Chi-Squared analysis. Due to the small numbers of participants, unprotected sex and sex with multiple partners categories were put into one group called 'risky sexual behaviour' (see Table 11).

Having used tobacco in the 3 months after the holiday was associated with having taken part in risky sexual behaviour during this period ($P < 0.05$). There were no other significant findings.

Table 11: Risky sexual behaviour of participants by substance use at each stage of the survey

		Risky Sexual Behaviour								
		Stage 1			Stage 2			Stage 3		
		Yes (%)	X ²	P	Yes (%)	X ²	P	Yes (%)	X ²	P
Alcohol	Yes	20.5			24.1			17.5		
	No	0	constant		0	0.315	0.575	0	0.211	0.65
Tobacco	Yes	22.2			36.4			31.3		
	No	20.0	0.031	0.86	15.8	1.648	0.199	7.7	3.958	>0.05
Cannabis	Yes	16.7			20.0			0		
	No	21.6	0.077	0.78	24.0	0.37	0.847	19.4	1.4	0.24
All other drugs	Yes	0			0			20.0		
	No	24.3	2.141	0.14	25.9	1.014	0.314	18.4	0.007	0.93
Drunkenness	Never	20.0			60.0			17.6		
	Once a week	23.1			0			18.2		
	2 or more days a week	12.5	0.422	0.81	21.1	5.639	0.06	33.3	0.429	0.81

Having used tobacco in the 3 months after the holiday was associated with having taken part in risky sexual behaviour during this period ($P < 0.05$). There were no other significant findings.

5.3.6. Health information, advice and treatment

Participants were asked about their use of health services before, during and after their holiday. Questions included the number of times at each survey they had injured themselves, felt ill/ hungover, had got into a fight or thought they were pregnant or had got someone else pregnant after consuming alcohol or drugs. Participants were also asked if they had missed an appointment, work or a lecture at survey 1 and 3 of the survey (not whilst on holiday). At each survey, the questionnaires also asked if participants had received any health related literature or any sexual health related services (i.e. pregnancy test, STD check-up).

Of all the participants, 31.9% had visited a doctor before their holiday, 8.5% during their holiday and 46.2% on return from their holiday. Only 9.2% has received any health advice or information at survey 1, 5.8% at stage 2 and 4.3% at stage 3.

The sample was too small to measure any significant changes in frequency of injuries, fights, being hungover or getting/being pregnant.

5.4. Discussion

This study set out to use longitudinal methods to measure changes in substance use, sexual and health seeking behaviours in holidaymakers over significant periods of time; before, during and after the holiday. The aims of this study were to contribute towards an understanding of appropriate methods of measurement of risk behaviour; and to provide data on various types of holidaymakers visiting a variety of destinations. It was initially expected that this would allow for the identification of patterns of substance use and risky sexual behaviour between specific types of tourists, such as youth package holidaymakers. It was also hoped that the data would allow for changes in behaviour to be measured over time, such as recruitment to drug use or excessive alcohol use whilst on holiday. This would allow for further understandings of temporary ‘liminal’ behaviour in holiday destinations to be explored (Andrews & Roberts, 2012; Eiser & Ford, 1995; Thomas, 2005; Wickens & Sonmez, 2007). It was noted that there were only a small number of studies that had adopted longitudinal methods for measuring tourist behaviours (e.g. Apopolostoulous et al., 2002; Klunge-De Luze et al., 2014), and most of this research only used a two-stage analysis. For that reason, a three-stage longitudinal study was used for this study. The results of this longitudinal holidaymaker’s study could be seen as reasonably inconclusive due to the small sample size, therefore the research question (3) *‘what changes in levels of individual’s risk and health seeking behaviours take place pre and post travel?’* may not have been necessarily answered to the level anticipated at this stage. Nevertheless, some important findings were uncovered that highlight the value of using a longitudinal study for this specific type of tourism nightlife research.

Only a small percentage of all of the participants reported that they were travelling for the purpose of sexual encounters (2.1%) or drug use (2.1%). The majority of participants reported that they chose their travel destination for the weather (63.8%) and culture (42.6%)

which may have dictated the destination and type of holiday behaviours they were partaking in. However, in using 'culture' as a point of reference for choosing a holiday it has to be considered that many may have seen 'nightlife' or even 'drugs' as part of a destination culture, which may have been confusing for the participants. As the study surveyed quite a wide spread of the public through snowballing techniques, this meant that the number of people that may have taken part in risk behaviour such as excessive alcohol or drug use may have been substantially diluted. Only a small number of participants could be identified as visiting a specific nightlife orientated holiday destination, such as Ibiza; yet it could not be certain that they were visiting these destinations to take part in nightlife behaviours exclusively. Nevertheless, around a third of participants reported that they chose their holiday destination for the nightlife (34.0%), with high levels of bar attendance throughout the holiday period. Additionally, of the four participants that specifically reported travelling to Ibiza on holiday, they all reported that they chose this destination for the nightlife and music. Previous studies have looked further into holiday expectations and predictions for holiday behaviour (Ragsdale et al., 2006; Sonmez et al., 2006). For example, a study of young spring break tourists revealed that they specifically chose their holiday destination for the expectation of access to alcohol and sex, with 42% of males reporting that they intended to experiment sexually during this time (Sonmez et al., 2006). To decipher further the motivations and expectations of the participants and reasons for choosing that specific destination, my study could have benefited from an additional question in the survey about their expectations for their trip.

The findings showed that there was an increase in those attending bars and nightclubs whilst on holiday, with 18.2% reporting visiting a nightclub two or more times a week whilst at home in the UK, rising to 36.2% visiting a nightclub two or more times a week whilst on holiday. However, this figure is not necessarily surprising as out of the participants that were

surveyed the majority of them were students (42.6%) or employed full time (51.1%).

Therefore, commitments such as employment or studies would naturally inhibit the amount of times that an individual may be able to visit a nightclub on a weeknight, for example.

Additionally, although there was an increase in bar and nightclub attendance whilst on holiday this does not mean that participants were consuming alcohol whilst on the premises; and some may have classed bars as a bar/restaurant if they were out for a meal. In terms of the findings, these factors must be taken into consideration, especially when surveying such a varied sample population visiting many different holiday destinations.

Unlike the study of casual workers in Ibiza, the study found that drug use actually decreased whilst on holiday and also post-holiday compared with pre-holiday use; with 12.8% of participants using illicit substances throughout all three stages of the survey. Therefore, with low levels of reported drug use by participants it was difficult to extrapolate any significant data. Although the findings did not show any significant increases in alcohol or drug use at each stage, significant increases in the frequency of alcohol use during and post- holiday was identified. This is in line with previous studies into frequency of alcohol use on holiday (Bellis et al., 2007; Hughes et al., 2008; Tutenges & Hesse, 2008). Nevertheless, this relates to the previous point that the majority of participants were students or employed full time, which may have been inhibiting factors for drunkenness as they will have to be able to function and hold down a job or studies.

Of the holiday destinations that participants visited, many may not have been specifically targeted towards increased alcohol use or nightlife. However, non-nightlife-related holiday destinations may still have local drinking cultures and practices that may influence drinking behaviours of tourists (Bell, 2008). Within periods spent on holiday, tourists may seek activities such as drinking alcohol around the pool or at the beach as this may fit with stereotypical ideologies around holiday behaviours of sun, sex, sea and sangria (Batalla-

Duran et al., 2003; Diken & Lausten, 2004; Hobson et al., 1995; Rogstad, 2004). Similarly, holidaymakers may feel a need to escape the stresses and responsibilities of home, using alcohol as a facilitator for full relaxation and immersion into the holiday environment.

Similar to drug use, the proportion of participants reporting having sex during their holiday period decreased from their pre-holiday activity. However, there was a five-fold increase in the number of partners reported with an increase from 0.09 partners per week at pre-holiday home, to 0.53 partners per week whilst on holiday. Only three participants reported having had more than one sexual partner whilst on holiday, and with such small numbers the findings are not able to provide an accurate representation of holiday behaviours in general. Moreover, the proportion of participants who reported having had multiple sexual partners actually decreased on holiday; the time frame of three months pre and post-holiday, compared to the short time frame of the holiday may have accounted for these numbers.

Around two thirds of participants that completed the full survey process had a sexual partner or spouse at each stage and this may have affected findings related to risky sexual activity or sex with multiple partners. For example, of those who had sex at every stage of the survey, 42.9% reported an instance of unprotected sex; however, it could be said that the risks of STD transmission could potentially be less in sex with a long-term trusted partner or spouse. This notion is supported by the fact that only a very small proportion of participants reported having had regrettable sex at any stage of the survey. As the study measured condom use, other contraception use and non-contraception use, it was hoped that this would tease out instances of completed unprotected sex. However, it must be considered that with such a high rate of participants traveling with sexual partners or spouses that they may have either been trying to get pregnant or using a withdrawal method.

The findings showed that a very small proportion of participants visited a doctor or hospital during their time on holiday (8.5%); yet a significantly higher proportion sought healthcare

before and after their holiday. It is unclear whether these visits to the doctor or hospital were related to pre-travel advice or illness or injury as a cause of the holiday, and therefore the findings were inconclusive. A further study may benefit from enquiring about the reason for visiting a hospital or doctor, particularly post-holiday, to capture information on the effect of holiday behaviours on health. The study found that only a very small number of participants received any healthcare information or literature on drugs or alcohol or sex; which was a similar finding to the Ibiza casual workers study. This again highlights the need for more accessible and widely distributed pre-holiday health advice, which could be delivered by organisations like holiday companies or holiday 'reps' and targeted in particular ways that are tailored to specific groups, such as backpackers and nightlife holidaymakers.

It was hoped that the longitudinal study may have incorporated the study of the three stages of liminality as outlined by Van Gennep (1960) of separation, transition and reincorporation (before, during and after). This may have allowed for a more in-depth understanding of perceptions of risk and how people's behaviour and attitudes may change throughout the holiday period. Theoretically, the study does relate to the concept of 'liminality' as holidaymakers are entering a 'liminoid' space in which they are away from normal structures and responsibilities at home (Shield, 1991; Turner, 1967). Nonetheless, when looking at a wide population of holiday-makers all visiting different destinations it is difficult to conclude that all the sample population were sharing the same feelings of a 'suspended identity' (Turner, 1982) or took part in play or experimentation on holiday (Graburn, 1989). Andrews (2005, 2011) identified that tourists can often seek the familiar of 'Britishness' and find themselves taking part in behaviours that they might at home in foreign destinations, such as eating traditional British food, visiting British pubs, or seeking the company of fellow British holidaymakers. This was a way to reinforce their identity and social status within an unfamiliar setting. Cohen (1974) and Nash & Smith (1991) argued that only some tourists

undergo a liminal experience as their residual culture may be so deep rooted that they cannot let go of their normal structures, routines and habits. For that reason, with such a small sample size, and also a sample that is not necessarily homogenised, it is difficult to draw any theoretical conclusions about young people and risk on holiday when looking at this particular study on its own. In order to fully understand the risk behaviours of people before, during and after their time spent on holiday and draw links to theoretical literature, the study would have benefited from looking at individual case studies from the sample. For example, looking at one person's journey through their holiday experience, using qualitative explorative methods, instead of a short survey.

As previously mentioned, there are no existing studies in the published literature that have used a three-stage longitudinal study to look at changes in nightlife behaviours in tourists; with the majority only cover a two-stage process (e.g. Vivancos et al., 2010). However, it is important to look at pre and post-holiday, especially in terms of substance use to see if any participants have been recruited to drug use. Additionally, there is a need to look at increases in risky behaviours, such as excessive alcohol use, to see if this has increased post-holiday as a result of the holiday environment. However, using longitudinal studies can come with a range of sampling issues, to be discussed.

Study limitations

In terms of the applicability of using a three-stage longitudinal study, such methods may always face obstacles due to drop out rates. Participants may lose interest or lack motivation to see a study through until the end. Moreover, participants may get frustrated with numerous email reminders that get sent out, dissuading them from taking part. For that reason, it is important that future studies take measures to gather the largest sample possible to account for this. To do this a sample size calculation could have been used to gain a better idea of

how many completed surveys would be needed to provide significant results, however at the time this option was not considered due to a lack of knowledge of the benefits of such a method. The variability of participant demographics additionally meant that the data may have been quite diluted in terms of the wide range of holiday and traveller types, yet the small sample did not allow for generalisations to be made for each group; for example, between long-haul travellers and nightlife tourists. Here, more targeted approaches may be beneficial, such as concentrating on only students visiting particular types of destinations.

Nonetheless, the take up and drop-out rates of participants could have been due to the fact that there was no incentive to complete all three surveys. For that reason, a reward incentive, such as a voucher or money may have served to keep participants interested and involved in the survey process. Students in particular may be keen to sign up for studies that have a financial incentive as they may use this as a source of income or use vouchers to pay for food and clothing. The result of such an approach may have been higher participation rates and consequently greater data available for analysis, however due to funding restrictions this could not be offered. Similarly, it was felt that the questionnaire was short enough and of a topic that may generate discourse and attract participants' continued interest.

The use of convenience and snowballing sampling may have proved reasonably detrimental to this study in terms of narrowing the population of participants, and slowing the process of data collection. The sample at the first stage of the survey was made up of 57.1% students and 34.2% employed full time, the remainder being unemployed or employed part time. The study target sample was heavily student based due to the convenience of being able to access mailing lists of students within the Liverpool John Moores University networks. The specific time frame for the collection of data over the summer months may have limited the recruitment of students as it was outside of term time and many participants would have limited access to university emails. For that reason, the sample cannot be deemed as

representative of a broader population of 16-35 year olds in wider society. In hindsight, wider means of communication should have been sought, such as social media tools and increased flyer-ing, going beyond snowballing techniques to reach wider networks. The use of magazine or radio adverts potentially may have increased the participation of individuals from the general population, and reached a broader range of individuals from different backgrounds, genders and employment markets, for example. However, at the stage of survey distribution the high drop-out rates could not have been anticipated, therefore in implementing this study this has proved a learning curve for future sampling methods.

The use of an online survey may have been detrimental in terms of not having an up-to-date email contact lists as many participants may have changed over the year long period, also many emails may have gone to junk mail. Using paper copies and online surveys may be more effective for future studies as this will allow for the direct face-to-face contact with participants; however, this may carry further cost implications in terms of the time required for delivery and distribution of questionnaires. This method may have allowed for the development of sustained research relationships of trust and mutual interest in the research topic. Nevertheless, the anonymous nature of an online survey may suit people better in divulging information about their sexual behaviour and drug use.

The quantitative data that were collected may have been supported by the use of interviews or focus groups, as used in previous studies (e.g. Elliot et al., 1998). This would have helped to test the validity of participants' answers and gain further understanding of their behaviours and holiday experiences. Yet this would have been a difficult undertaking logistically as the nature of the online survey recruitment using social networks meant that a large proportion of the sample were not based in Liverpool. With such a small sample of participants, it was also felt that interviews and focus groups would not have added a great deal to the data that had been collected, particularly as there was not a great deal of significance in the findings.

The inclusion of sensitive questions about sexual behaviour and substance use may have affected compliance rates. Participants may have differing views on the deviant associations with substance use and stigmas attached to sexual promiscuity, affecting their response rates to these questions. To overcome this, participants were informed that they did not have to answer any questions that made them feel uncomfortable and that all responses would remain confidential and would not be disclosed to any other parties.

The use of online questionnaires means that participants may have received assistance in completing the questionnaires or that they may have been influenced by peers present during completion. This could have potentially affected both the drop- out rate and the compliance rates if participants were dissuaded from completing the questionnaires by others; or were encouraged to exaggerate or spoil their surveys. To attempt to decrease the chances of group participation, participants were advised to contact the researcher should they need any assistance. However, in using the online questionnaire method validity of answers cannot be guaranteed in each case.

5.4.1. Conclusion

The objective of this study (d) was to *trial a method that measured longer-term risk using a novel three-stage longitudinal study, looking at risk behaviour pre, during and post-travel.*

This was to fit the wider aim of the study to identify risk behaviours in different groups in different contexts and their utilisation of health services. Although it can be said that the findings of this study are reasonably inconclusive, they do contribute to a body of knowledge, particularly around research methods. It is easy to make recommendations for future research in hindsight of conducting this study, yet the processes I went through have been invaluable to me in terms of how I might design and deliver a longitudinal study of this kind again.

The way in which a holiday can affect individuals' norms and behaviours is a phenomenon that is important for public health research in terms of harm reduction. This has been particularly highlighted in the first study of Ibiza casual workers. Although it was hoped that the study would contribute towards a theoretical understanding of 'liminality' and 'situational disinhibition' it would not be appropriate to make generalisations at this stage.

In gaining an understanding of adopted behaviours, services and literature can be tailored to fit with the needs of travelling populations both pre, during and post-holiday, to ensure that individuals can be reached at every stage of their seasonal travel. For that reason, this three-stage approach would be useful to adopt for future research; although perhaps using different sampling methods may be more appropriate. In conclusion, and in answer to the research question (3) this study identified no significant differences in risk behaviours pre, during and post-travel, or between tourist types in this particular sample. However, in looking at individual change amongst the cases, there is evidence to support that this concept could be proved in further research.

Chapter 6: The Liverpool tourists' study

6.1. Introduction

City breaks have been recognised in urban tourism related literature for their growing popularity and particular characteristics around spending a few days sightseeing in a large city destination (Dunne et al., 2007, 2011; Law, 2002; Trew & Cockerell, 2002).

Nevertheless, as highlighted in the literature review, there are very few health related studies that have highlighted the substance use or sexual behaviours of tourist populations on ‘city breaks’ in Europe. The majority of research has focused primarily around beach destinations such as Sunny Beach, Bulgaria (Tutenges, 2013; Hesse & Tutenges, 2008), Ibiza (Bellis et al., 2003; Briggs, 2013) or spring break locations such as Florida (Josiam et al., 1998).

Additionally, as identified in the literature review, there are no existing studies of risk behaviours of international tourists visiting the UK in particular. Moreover, the small amount of health related research on city break tourism has mainly involved the study of the substance use or sexual behaviour of stag and hen tourists (Eldridge & Roberts, 2008; Thurnell-Read, 2012, 2014). Therefore, the objective of this study was to:

(e) Measure the risk taking behaviours of young tourists visiting the UK as a city break destination by implementing a short quantitative study among national and international visitors to Liverpool, examining levels of substance use, sexual behaviour and utilisation of existing health services;

Popular city break locations in the UK include London, Newcastle, Manchester, Leeds and Liverpool, all characterised by thriving nightlife industries. The aims of this thesis are to explore different tourist types in differing contexts; therefore an opportunity to gather information on this relatively unstudied population. The study was also seen as a chance to explore how theoretical understandings around health risk in holiday environments could be applied to a relatively unstudied holiday area. In particular, such a study is useful to gain

information on the utilisation of health services by visitors to the UK. For that reason the research question (4) '*what risk and health seeking behaviours are exhibited by young travellers visiting a UK city break destination?*' was formulated.

The North West of England in particular is home to some of the largest nightlife centres in the UK, such as Manchester, Blackpool and Liverpool. The region alone has over 10,000 bars and nightclubs, and the nightlife economy is of significant importance to the region's tourism economy (Hughes & Bellis, 2003). Liverpool is a tourist destination with a population of around 470,000 people and attracts 75 million tourists each year (Liverpool City Council, 2014). The city was named European Capital of Culture in 2008, attracting masses of international visitors and bringing much regeneration into the city. The city is abundant with internationally renowned museums, theatres and art galleries (Whiteford & Byrne, 2012) and annual events such as the Matthew Street Festival, Creamfields and Liverpool Sound City, and therefore continually draws international tourists.

Liverpool's historical reputation as a music and nightlife capital attracts both national and international tourists and the city has been home to many famous music acts, most notably The Beatles. The late 1990s saw Liverpool regarded as a '24 hour party' city that underwent urban regeneration around its nightlife economy (Aldridge et al., 2011). The city is celebrated for its relationship with the house music scene of the 1980s/1990s, with some of the most prolific nightclubs and dance music brands, such as Cream and Garlands established at this time



in Liverpool (Aldridge et al., 2011; Luke et al., 2002; Young et al., 2010). Cream in particular has expanded from Liverpool into a globally recognised entertainment brand, with the city still playing host to its annual summer festival 'Creamfields'. Cream and Garlands

brands still have links with the destination of Ibiza, with resident DJs from Liverpool hosting dance music nights in the large ‘Superclubs’ on the island (Aldridge et al., 2011; Sellars, 1998).

Nearly one third of Liverpool’s population are aged between 16-39 years (Liverpool City Council, 2014), and the city attracts a large student contingent, meaning nightlife arenas are particularly popular (Bellis & Hughes, 2005). The city has a large range of nightlife venues, made up of traditional public houses, fashionable bars and nightclubs, of which many are increasingly extending their licenses to stay open later than in many comparative English cities (with closing times between 5am-7am) (Rouse, 2014). In 2014, it was measured that Liverpool had the largest number of 24-hour licensed drinking venues in the North West (Rouse, 2014). Such late night venues house DJs playing typically chart and dance music, attracting many house music enthusiasts. Popular narrative describes Liverpool as a hedonistic party city, and it has been previously dubbed the ‘alcohol capital of England’ (Whiteford & Byrne, 2012; Williams, 2011).

Drinking levels are particularly high in Liverpool with Friday and Saturday nights being the busiest and heaviest drinking days (Anderson et al., 2007). A study from 2009 measured blood alcohol levels and drunkenness in people visiting Liverpool, Manchester and Chester’s nightlife at weekends, and found that 60.7% of males and 44.6% of females had drunk more than the recommended weekly alcohol limit in one night; with 49.5% reporting being drunk at the time of interview (Hughes, Anderson et al., 2009). In the past decade, Liverpool has consistently measured one the highest levels of alcohol-related hospital admissions in England (Whiteford & Byrne, 2012). A study of hospital admissions of nightclub attendees in Liverpool found that most were aged between 18-25 years and that the majority were admitted due to injuries gained from violence, such as assault, commonly as a result of alcohol intoxication (Luke et al., 2002). In terms of sexual behaviour, figures have shown that

Liverpool has high levels of sexual activity related to nightlife-related substance use (Bellis et al., 2008). In the same study alcohol, cocaine and cannabis were found to be used to facilitate and enhance sexual encounters, with those who had been drunk in the previous four weeks reporting to be more likely to have had multiple sexual partners and unprotected sex.

Liverpool has a noted history with recreational drug use and has also been dubbed the ‘drug death capital of England’ (Selby, 2014). Young people (aged 18-35 years) in particular have been found to consume substantial amounts of illicit substances in nightlife arenas in Liverpool, with cocaine and ecstasy reported as the most commonly used drugs (Anderson et al., 2007; Bellis et al., 2008). Liverpool is reported to have particularly high levels of cocaine use due to its position near a major shipping port (Selby, 2014). In a study of nine European nightlife cities, Liverpool had the highest proportion of participants reporting having used cocaine (50%) and the second highest level of ecstasy users (46.9%) (Bellis et al., 2008). In 2015, concerns were voiced that the strength of drugs in Liverpool was increasing due to decreased wholesale prices; leaving users more likely to suffer an overdose (Siddle, 2015). According to the DrugScope annual survey for 2014, police in Liverpool had reported that cocaine purity had increased from a single figure to 25%, whilst heroin had increased from 25% to 40% (Daly, 2015). The survey also reported new trends in the use of new psychoactive substances (NPS) in Liverpool, including a trend in students using nitrous oxide gas canisters to get high.

In terms of existing healthcare in Liverpool, there are a number of hospitals around the city, including the Royal Liverpool University Hospital, based on the outskirts of the city centre. Liverpool also offers a NHS walk-in service that can be used by patients that are not registered to a doctor’s practice within the city. This service offers basic level healthcare from doctors and nurses, and can be utilised by visitors to the city (see Appendix 11). The city also has a number of nightlife orientated initiatives in existence, including ‘CitySafe’, a

community safety partnership delivered by the local council that, amongst a range of things, is behind campaigns working with students to improve their nightlife safety (Liverpool City Council, 2015). Such campaigns and health-related initiatives are not only designed for Liverpool residents visiting nightlife arenas, but also visitors from all across the UK and the rest of the world.

Taking this into consideration, Liverpool was chosen as the location for the study of young international travellers to a British nightlife destination.

6.2. Methods

6.2.1. Initial obstacles

The study faced a number of methodological obstacles from the outset with sampling methods and research locations. The initial proposal for the study comprised an airport based study, using short quantitative questionnaires to be delivered to young international travellers who had visited Liverpool. This would have included the distribution of questionnaires in the departure lounge of Liverpool John Lennon Airport to visitors from a selection of European countries, including France, Germany and Italy. Scholars have used this method of data collection successfully in previous studies; therefore, this study would have been based on this model (e.g. Hughes & Bellis 2004; Hughes et al., 2011; Thomas, 2005). The target sample was initially chosen based on the frequency of flights departing to each country on a daily basis from the airport. This could have potentially generated a large number of completed questionnaires over a reasonably short period. It would have also proved an efficient method of targeted sampling as suitable participants would all be present in one area at set times throughout each day of the study.

The airport is an area of strict security restrictions and protocol, and therefore receiving permission to complete research in such an environment can be troublesome and a lengthy procedure. Ethical approval was sought from Liverpool John Moores Research Ethics Committee (see Appendix 12) and all necessary measures were put in place (UK General Security Awareness Training and Criminal Records Bureau Certificate) to progress with the research study. Additionally, informal meetings were held with the airport head of security at that time. After initially receiving permission to enter the airport to complete the study, unexpected last minute complications arose with the airport implementing changes to their security provider and staffing at the proposed time of the study. This meant that the

applications for permission to complete research at the airport had to be re-submitted to their new members of senior security staff. Ultimately, this resulted in all applications being rejected and the research project being cancelled without adequate explanation, and at a critical time.

Consequently, the research study faced time restrictions as the distribution of questionnaires was always planned to take place over the summer months due to the increased amount of visitors to Liverpool over this period. Liverpool hosts a number of festivals, outdoor events and attractions over the summer, such as Creamfields, attracting young people in particular to the city. As the airport study was cancelled in spring 2011, this left very little time to re-submit ethics forms and re-design a study framework, in order to avoid waiting another year to collect data the following summer. For that reason, it was decided that the original airport questionnaire that was designed could be implemented in hostels across Liverpool, housing international travellers visiting the city. Participants' behaviour during their stay could still be measured at the end of their visit to Liverpool by targeting individuals that were checking out of hostels after a weekend stay. This allowed for a short turnover time for the re-design of an adequate study, and time to source suitable hostel locations.

The following describes the methods that were utilised to collect data within hostels.

6.2.2. Amended method

Accessibility factors were taken into consideration due to the close proximity of potential participants to the research centre in Liverpool City Centre, minimising the cost of time of travel. The study took place at two city centre hostels, chosen in order to provide direct access to young international tourists that were staying in Liverpool for more than one day. Hostels were utilised in order to maximise the quantity of questionnaires that could be

distributed by recruiting participants in the dining and reception areas where both large and small groups of young international tourists congregated on a daily basis.

The study took place over a three-month period in August, September and October 2011, one of the busiest times of the year for visiting tourists to Liverpool. The hostels were chosen because of their central location in Liverpool and the hostel managers were approached to obtain permission to access individuals staying on their premises and distribute questionnaires. From this, both hostel locations agreed to allow access to collect data. Hostels were visited on Sunday and Monday mornings for four-hour periods in order to capture the weekend behaviours of young tourists. Typically, young tourists were staying for a weekend period and leaving on either a Sunday or Monday afternoon and often congregated in the reception check out areas, which proved an ideal research area.

Ethical approval for the amended method was received from Liverpool John Moores University Research Ethics Committee (see Appendix 12)

6.2.3. Quantitative questionnaire

To answer the research question (4) a short questionnaire was used to maximise the potential for participant involvement in a busy setting. The questionnaire structure was kept simple and concise to allow participants to complete in around five minutes, therefore increasing recruitment rates. This enabled participants to partake whilst dining or lounging in the reception areas of the hostels, and did not interrupt their daily activities. The questionnaire structure remained similar to that used in both the Ibiza casual worker study and the longitudinal holidaymaker study, allowing for consistency and the continuation of a standardised method of data collection. The questionnaire was originally based on a tested structure used in previous studies (e.g. Hughes & Bellis, 2004, 2006).

Due to the differing nationalities of participants inhabiting each hostel the questionnaires were translated into English, French, Spanish, Dutch and German (see Appendix 13). The translations were undertaken by researchers within the Centre for Public Health, LJMU and university researchers from around central Europe affiliated to LJMU who were fluent in each language. The choice of language translation reflected the most common flights arriving from around Europe into Liverpool John Lennon Airport at the time of the study. The study additionally took into consideration the high levels of UK visitors to Liverpool for leisure and holidays; consequently for UK participants the questionnaire was adjusted slightly in order to record city of origin rather than country of origin.

The questionnaire was designed to maximise the amount of data gathered from international participants about their levels of substance use and sexual behaviour whilst in Liverpool. It gathered information on the basic demographics of participants before looking at the following themes (see Appendix 14):

- The reasons for visiting Liverpool and intended length of stay.
- Participants' involvement in nightlife related activities by measurement of bar and nightclub attendance.
- Participants' levels of substance use previously at home and during their stay so far in Liverpool.
- Participants' levels of sexual activity previously at home and during their stay so far in Liverpool.
- Participants' use of healthcare services in Liverpool for alcohol, sex and drug related illness or injury.

6.2.4. Recruitment

The target sample was young international or British individuals aged between 16-35 years who were visiting Liverpool for leisure purposes, and were residing in the city for a minimum period of two days. Participants were approached in the dining and reception areas of the hostels opportunistically as they entered and departed the survey area. Individuals were asked if they had time to fill in a short survey (n= 147), and those who were willing to take part (n=111) were informed about the nature of the study verbally and given a participant information sheet. Verbal consent was gained from participants before they were handed the questionnaire to complete. Participants were informed of their anonymity and their right to withdraw from the survey at any point. Refusal and consent rates were recorded on a separate sheet for reference.

Participants were handed a questionnaire, a clipboard, a pen and an envelope and asked to self-complete the survey in the dining or reception area, then to place the completed questionnaire into a sealed envelope and hand this back the researcher. They were then asked to inform the researchers should they require any assistance and not to confer with any other individuals in the area. Some participants requested assistance from researchers who read out the questions and assisted in ticking the boxes required. This was due to minimal language and communication barriers and participants who did not have time to complete the survey themselves. All completed questionnaires were stored in a secure folder and returned to the Centre for Public Health at the end of the study period for analysis.

6.2.5. Analysis of findings

Data from the short questionnaires were entered into an SPSS database for analysis, using Chi-squared and logistic regression to test for independent relationships between variables.

6.3. Findings

6.3.1. Characteristics

Participants' demographics are presented in Table 12 as well as factors associated with their stay in Liverpool by gender. There were no differences between genders in age, country of residence or length of stay so far in Liverpool. Of the 111 participants, 64.5% were male and 35.5% female. The mean age of participants was 24.2 years, with nearly two-thirds aged between 18-24 years old.

Table 12: Tourist characteristics

		All		Male		Female		X ²	P
		%	n	%	n	%	n		
Age group	18-24	59.3	64	52.9	37	71.1	27	3.378	0.066
	25-35	40.7	44	47.1	33	28.9	11		
Country of residence	UK	34.5	38	38.0	27	28.2	11	3.510	0.320
	Ireland	12.7	14	9.9	7	17.9	7		
	Europe	28.2	31	31.0	22	23.1	9		
	International	24.5	27	21.1	15	30.8	12		
Stay so far in Liverpool	1-2 days	31.8	35	35.2	25	25.6	10	1.063	0.588
	3-7 days	44.5	49	42.3	30	48.7	19		
	>7 days	23.6	26	22.5	16	25.6	10		
Travel group type	Travelling alone	11.2	12	10.1	7	13.2	5	10.858	0.013
	Couple (mixed or same sex)	11.2	12	13.0	9	7.9	3		
	Single sex group	41.1	44	50.7	35	23.7	9		
	Mixed sex group	36.4	39	26.1	18	55.3	21		
Nights visited a pub/bar in Liverpool	None	13.5	14	7.6	5	23.7	9	5.663	0.129
	Less than half	18.3	19	18.2	12	18.4	7		
	at least half, but not every night	36.5	37	37.9	25	31.6	12		
	Every night	32.7	34	36.4	24	26.3	10		
Nights visited a nightclub in Liverpool	None	33.7	35	30.3	20	39.5	15	3.539	0.316
	Less than half	27.9	29	27.3	18	28.9	11		
	at least half, but not every night	15.4	16	13.6	9	18.4	7		
	Every night	23.1	24	28.8	19	13.2	5		

The questionnaire asked participants how long they had been staying in Liverpool by the time of the survey and how much longer they intended to stay. The mean length of stay by the time of the survey was 11.5 days, and the mean total stay in Liverpool was 19.2 days.

Participants were asked how many males and females they were travelling with; 11.2% were travelling alone or with a partner, whilst the majority were travelling in either a mixed sex (36.4%) or same sex (41.1%) group. The questionnaire asked participants about their attendance at pubs/bars and nightclubs. Around a third of participants visited bars/pubs more than half of the nights (36.5%) or every night (32.7%) of their stay in Liverpool, whilst almost a third of participants (33.7%) did not visit a nightclub during their stay in Liverpool. There were no gender differences in pub/bar or nightclub attendance (Table 12).

Table 13: Frequency of participants reasons for choosing Liverpool by country of residence

	Culture	Weather	Sex	Nightlife	Work	Music	Festival/Event	Drugs	Visiting family/ friends	Other
<i>n</i>	42	3	12	52	1	12	19	2	14	39
UK	9.5	33.3	50.0	55.8	0	33.3	31.6	50.0	28.6	28.2
Ireland	4.8	0	50.0	21.2	0	0	15.8	50.0	7.1	7.7
Europe	38.1	0	0	11.5	100.0	33.3	31.6	0	35.7	35.9
International	47.6	66.7	0	11.5	0	33.3	21.1	0	28.6	28.2
X ² between locations	<0.001	0.322	<0.001	<0.001	0.462	0.518	0.933	0.329	0.804	0.319

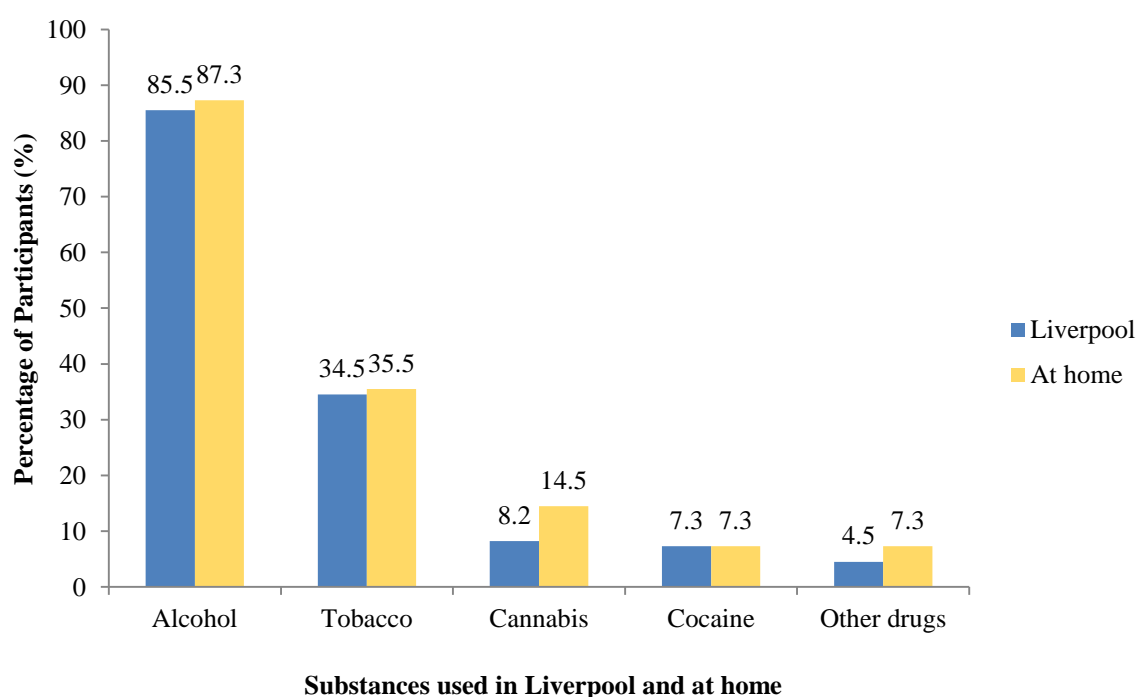
Participants were asked why they chose to visit Liverpool and were presented with a list of possible options (see Appendix 14). Nearly half of all participants reported that they were visiting Liverpool for the nightlife (46.8%) and over a third that they were in Liverpool for

the culture (37.8%). There were no differences in gender for any of the options for choosing to visit Liverpool, however there were significant differences for country of residence (See Table 13).

6.3.2. Substance use

Participants were asked about their substance use whilst at home and during their stay in Liverpool, allowing for a comparison of patterns of use in both locations. The substances listed were alcohol, tobacco, cannabis, cocaine, ecstasy, amphetamines, ketamine and gammahydroxybutyrate (GHB). Participants were also asked if they had used any other substances in Liverpool (e.g. legal highs). Both use at home and in Liverpool was measured on a weekly scale (see Figure 8).

Figure 8: Percentage of participants using substances in Liverpool and at home



As seen in Figure 8 there was little difference in use of alcohol, tobacco, cannabis and other drugs between Liverpool and at home. The vast majority of participants used alcohol, and around a third used tobacco in both locations. 15.5% of participants used illegal drugs whilst in Liverpool, whilst 20.0% of participants used illegal drugs at home. The most commonly used illegal drugs used in Liverpool and at home were cocaine and cannabis. There were no differences in age group or gender for use of substances in both locations. None of the participants reported using other drugs that were not listed, such as legal highs.

Of those who used an illegal drug in Liverpool, nearly half were national tourists (i.e. from the UK; 47.1%), and around a quarter of users were from outside of Europe (23.5%).

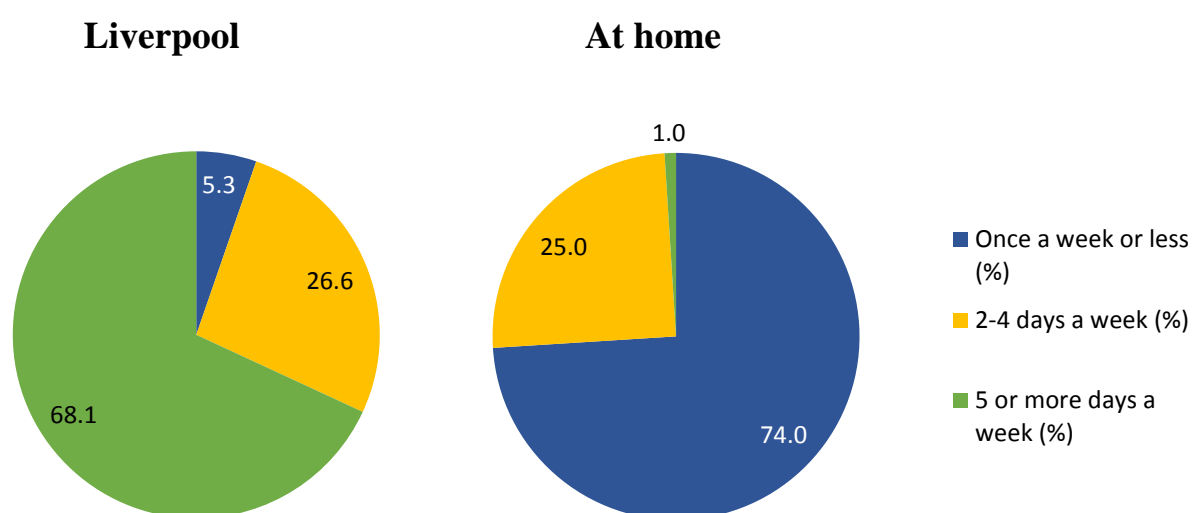
National and international visitors' substance use was measured to draw comparisons. As shown in Table 14 a higher proportion of national visitors used most substances whilst in Liverpool, apart from cannabis; in particular a greater proportion of national visitors used cocaine (15.8%) compared to international visitors (2.8%). The patterns of frequency of use were not compared for national and international travellers as separate groups as the sample sizes were too small to provide meaningful results.

Table 14: Percentage of visitors using substances in Liverpool, comparing national to international visitors

	National Visitors		International Visitors		X ²	P
	%	n	%	n		
Alcohol	97.4	37	79.2	57	6.630	<0.05
Tobacco	44.7	17	29.2	21	2.667	0.102
Cannabis	5.3	2	9.7	7	0.658	0.417
Cocaine	15.8	6	2.8	2	6.244	<0.05
All other drugs	7.9	3	2.8	2	1.501	0.221

The questionnaire enabled the measurement of changes in frequency of use of all substances in Liverpool compared to use at home. The pattern of alcohol use changed with 68.1% of participants that used alcohol in Liverpool drinking five or more times a week, compared to only 1.0% using alcohol five or more times a week at home (see Figure 9). Just under half of those participants that used alcohol (43.6%) reported being drunk five or more times a week whilst in Liverpool, whilst a quarter (24.5%) reported being drunk 2-4 days a week.

Figure 9: Frequency of alcohol use per week in Liverpool and at home among those who used in both locations



It was not possible to measure if there were any significant changes in the frequency of use of ecstasy, cocaine, amphetamines, ketamine or GHB, due to low numbers of users in both locations. However, Table 15 shows significant changes in the frequency of tobacco and cannabis in Liverpool compared with home use patterns. For example, whilst 56.4% of participants used tobacco five or more times a week at home, nearly three quarters (71.1%) used five or more times a week in Liverpool.

Only 17 (15.5%) participants used any other illegal drug whilst in Liverpool. Thus, the numbers of users for each substance were too low to undertake any meaningful data analysis on polydrug use and recruitment to drug use.

Table 15: Frequency of use of tobacco and cannabis in Liverpool and at home

	Tobacco	Cannabis
<i>n</i>	38	9
Frequency of use Liverpool %		
Once a week or less	7.9	33.3
2- 4 days a week	21.1	33.3
5 or more days a week	71.1	33.3
Frequency of use at home %		
Once a week or less	38.5	62.5
2- 4 days a week	5.1	6.3
5 or more days a week	56.4	31.3
X ² between locations	<0.001	<0.001

6.3.3. Sexual behaviour

The questionnaire asked about sexual behaviour during the trip to Liverpool and in the past 12 months at home. Participants were asked if they arrived in Liverpool with a sexual partner or spouse. They were then asked with how many males and how many females they had sex with during their stay. To ascertain the type of sexual partner contact in Liverpool, participants that had sex were asked if sexual partners were tourists, local residents or other. Participants were then asked with how many partners they always used a condom, and if the participant had unprotected sex were they under the influence of alcohol or drugs at the time. Following this, participants were similarly asked if they had regrettable sex during their stay in Liverpool and again if this was under the influence of alcohol or drugs. Participants were finally asked how many sexual partners they had had in the previous 12 months at home.

Of all participants, 34.5% had sex whilst in Liverpool. Wilcoxon signed rank test found that participants had more partners per week whilst in Liverpool; a mean of 0.39 a week compared with 0.03 whilst at home ($P<0.05$). There were no differences in gender for having had sex or for the number of sexual partners had whilst in Liverpool. A greater proportion of international visitors (40.3%) than national visitors (23.7%) had sex whilst in Liverpool.

Table 16: Sexual behaviour in Liverpool by gender

Total sample		n=111							
		All		Male		Female		X ²	P
		%	n	%	n	%	n		
Visited Liverpool with a partner (%)		10.2	11	8.7	6	12.8	5	0.463	0.496
Had sex in Liverpool (%)		34.5	38	35.2	25	33.3	13	0.039	0.843
Sub sample: those arriving without a sexual partner		n= 98							
Had sex in Liverpool (%)		26.8	26	28.6	18	23.5	8	0.286	0.593
Number of sexual partners in Liverpool (%)	0	73.2	71	71.4	45	76.5	26	1.054	0.59
	1	22.7	22	25.4	16	17.6	6		
	2 or more	4.1	4	3.2	2	5.9	2		
Number of sexual partners in the last 12 months at home (%)	0	18.3	15	15.7	8	22.6	7	2.549	0.28
	1	45.1	37	41.2	21	51.6	16		
	2 or more	36.6	30	43.1	22	25.8	8		
Sub sample: those without a sexual partner who had sex		n=26							
Had unprotected sex (%)	Yes	28.0	7	29.4	5	25.0	2	0.053	0.819
	No	72.0	18	70.6	12	75.0	6		
Had Regretted Sex (%)	Yes	16.0	4	5.9	1	37.5	3	4.046	0.044
	No	84.0	21	94.1	16	62.5	5		

The majority (89.8%) of participants arrived in Liverpool without a sexual partner or spouse.

As shown in Table 16, those arriving without a sexual partner or spouse, just over a quarter

(26.8%) had sex in Liverpool; only 4.1% had sex with multiple partners during their stay. Of those arriving without a sexual partner and having had sex, 28.0% had unprotected sex and 16.0% had regretted sex, with females more likely to have had regrettable sex ($P<0.05$).

Table 17: Sexual behaviour of those arriving without a sexual partner or spouse, by participant characteristics

		Had sex			Had multiple partners			Had unprotected sex		
		%	X ²	P	Yes	X ²	P	Yes	X ²	P
Age group	18-24	28.8			1.7			12.5		
	25-35	25.0	0.164	0.686	8.3	2.443	0.118	55.6	5.297	0.021
Country of residence	UK	19.4			2.8			57.1		
	Ireland	53.8			0			16.7		
	Europe	20.0			4.0			0		
	International	30.4	6.584	0.086	8.7	1.941	0.585	28.6	5.277	0.153
Stay so far in Liverpool	1-2 days	14.7			0			60.0		
	3-7 days	28.6			2.4			20.0		
	>7 days	45.5	6.437	0.04	13.6	6.792	0.034	20.0	3.175	0.204
Travel group type	Travelling alone	50.0			8.3			0		
	Couple (mixed or same sex)	0			0			0		
	Single sex group	25.6			0			30.0		
	Mixed sex group	24.2	5.657	0.13	9.1	4.562	0.207	50.0	4.155	0.125
Nights visited a pub/bar during stay	None	0			0			0		
	Less than half	52.6			10.5			10.0		
	At least half, but not every night	37.8			2.7			42.9		
	Every night	29.4	10.84	0.013	2.9	3.059	0.383	22.2	3.334	0.189
Nights visited nightclub during stay	None	22.9			2.9			50.0		
	Less than half	48.3			6.9			14.3		
	At least half, but not every night	25.0			0			50.0		
	Every night	33.3	5.174	0.16	4.2	1.469	0.689	14.3	4.911	0.178

Participants in the higher age group of 25-35 were more likely to have had unprotected sex whilst in Liverpool ($P<0.05$). Those that had stayed in Liverpool longer were more likely to of both had sex and had sex with more than one sexual partner ($P<0.05$). Those who visited a pub or bar were found to be more likely to have had sex. There were no other significant predictors for sexual behaviour.

6.3.4. Substance use and sexual behaviour

Chi squared analysis was used to examine participants' sexual behaviour based on their substance use behaviours (see Table 18). Participants who used alcohol in Liverpool were more likely to have had sex during their stay ($P<0.01$), and those who used cannabis were more likely to have both had sex and had sex with more than one sexual partner during their stay ($P<0.01$). Although there was no significant relationship between sexual behaviour and frequency of drunkenness, all participants who had unprotected sex had used alcohol whilst in Liverpool.

Table 18: Sexual behaviour of participants by substance use in Liverpool

		Had sex			Had multiple partners			Had unprotected sex		
		Yes (%)	X ²	P	Yes (%)	X ²	P	Yes (%)	X ²	P
Substances used in Liverpool	Alcohol	32.1	7.017	0.008	4.9	0.824	0.364	28.0	constant	constant
	Tobacco	29.4	0.181	0.67	5.9	0.41	0.522	20.0	0.529	0.467
	Cannabis	66.7	8.035	0.005	22.2	8.219	0.004	33.3	0.111	0.739
	Other drugs	60.0	2.961	0.085	0	0.277	0.634	33.3	0.048	0.826
Drunkenness per week	Once a week or less	18.9			8.1			14.3		
	2-4 days a week	40.0			0			37.5		
	5 or more days a week	28.2	2.963	0.227	2.6	2.56	0.278	30.0	1.031	0.597

Logistic regression was undertaken to identify factors independently associated with sexual behaviour in Liverpool; looking at all factors (e.g. demographics, substance use) significantly associated with sexual behaviour in the chi squared analysis. However, there were no significant associations found.

6.3.5. Health information, advice and treatment

The questionnaire asked participants about their use of health services whilst in Liverpool, including the number of visits they had made to hospital or doctors during their stay, and whether this was related to a sex, alcohol or drug related illness or injury. Participants were asked if they had received any pre-travel health advice or literature about alcohol, sex or drugs, and if they had received any advice or literature whilst in Liverpool. The questionnaire then asked participants if they had required a sexual health check-up, a pregnancy test or emergency contraception during their time in Liverpool. Finally, participants were asked if they intend to receive a sexual health check-up on return home.

Only 5.8% of participants visited a hospital or doctor during their stay in Liverpool. 15% of participants received pre-travel health advice or literature before arriving in Liverpool, whilst 6.4% received health advice or literature whilst in Liverpool. No participants had required a sexual health check-up, emergency contraception or a pregnancy test during their time in Liverpool. One in eight (12.4%) of participants stated that they would be receiving a sexual health check-up on return home.

6.4. Discussion

The initial objective (e) of the study was *to explore the risk taking behaviours of 'city break' tourists visiting the UK, including their substance use, sexual behaviour and utilisation of health services*. The study has provided a snapshot of these behaviours, yet generalisations cannot be made from the data due to the small and diverse sample. The study methods faced difficulties from the outset, as mentioned in the methods chapter. For that reason, the study suffered from sample recruitment issues. The following will discuss relevant findings and aim to highlight areas that could be improved or amended for the purpose of future research. The study limitations will be highlighted throughout this section, rather than separated at the end as they form an important part of the discussion.

A higher proportion of participants used substances at home than in Liverpool across all substances apart from cocaine. For example, 14.5% of participants used cannabis at home, while only 8.2% used while in Liverpool. However, changes between locations were not significant due to the small number of drug users in the sample (n=17). Nevertheless, significant increases were shown in the frequency of use of some substances whilst in away from home. Among those who used alcohol, tobacco or cannabis both at home and away, greater proportions used five or more times a week in Liverpool. The greatest difference was seen in alcohol use, with 68.1% using five or more times a week in Liverpool, compared to only 1% using alcohol five or more times a week at home. This shows that visitors to Liverpool were taking part in concentrated use of substances over short periods of time, in particular drinking alcohol regularly throughout their visit. Additionally, nearly half of participants (46.8%) reported visiting the city for the nightlife, and around a third (32.7%) visited bars every night of their visit.

These findings are in keeping with trends from previous studies reporting increased frequency of use of substances in holiday destinations like Ibiza (Bellis et al., 2000; Hughes et al., 2004) Bulgaria (Tutenges & Hesse, 2008) and the USA (Sonmez et al., 2006). This highlights a proportion of visitors to Liverpool whose sole purpose of the trip may be to party and consume substances over consecutive nights, rather than take part in traditional tourist exploits such as sightseeing (Dunne et al., 2007; 2011). This is true in particular for national visitors to Liverpool, with greater proportions using both alcohol and drugs in Liverpool compared to international travellers. For example, 15.8% of national visitors used cocaine whilst in Liverpool compared to only 2.8% of international visitors. However, this may be due to differing cultures around substance use, such as drinking alcohol; and it must also be considered that national visitors may have easier access to substances and may have brought them to Liverpool as they did not need to cross any borders. Nevertheless, with a large police presence on the streets of Liverpool and at many train stations, it could be questioned whether carrying drugs is as easy for national tourists. They may also be visiting Liverpool for the sole purpose of a stag or hen do, whereby excessive drinking and partying is expected. Similarly, tourists may arrive in Liverpool with the intention of visiting tourist attractions such as museums, but then take part in excessive drinking or drug taking which may lead to individuals missing out on attractions due to hangovers.

Increases in alcohol use on holiday have been previously termed ‘alco-tourism’; whereby groups travel to holiday destinations to consume greater amounts of alcohol over a short period of time (Bell, 2008). The intention here is to fulfil the full holiday experience of partying and hedonism, and connect with local cultures and practices around drinking (Bell, 2008). With Liverpool being nicknamed the ‘alcohol capital of England’, this could mean that tourists are also adopting excessive behaviours around alcohol use as such risk arenas already exist in the city (Whiteford & Byrne, 2012; Williams, 2011). The literature review

identified that young people across the UK are regularly taking part in binge drinking behaviours on a weekend in their hometowns and cities (Measham, 2004; Measham & Brain, 2005; Szmigin et al., 2007). Therefore, the inclusion of national tourists from other areas of the UK visiting Liverpool leads to the question of whether their behaviour is actually different from what they take part in at home around alcohol use. When thinking about theoretical concepts such as 'liminality' and 'situational disinhibition' (Turner, 1982; Eiser & Ford 1995) it must be considered that individuals may not be entering a space where they might be acting differently or feel that they are in a temporary space where 'anything goes' (Bakhtin, 1984). If people's norms and behaviours around drinking alcohol are not necessarily changing while in this temporary holiday environment, then the level to which they are engaging in risk behaviours whilst in Liverpool may not differ than at home.

Although the focus of this study was on alcohol and drug use and sexual behaviour, this does not discount 'liminality' as a concept that can be related to tourists visiting Liverpool, as this is still a temporal space that may affect and shape people in different ways, not just in terms of their risk perceptions and behaviour (Andrews & Roberts, 2012; Shields, 1991).

Yet, the same might not be said for international tourists visiting Liverpool who may have differing norms and values around risk behaviour such as drinking alcohol excessively. A comparative study of young people from nine cities across Europe found that British youth from Liverpool were more likely to drink excessively and take illicit drugs than any other sample population from outside of the UK (Bellis et al, 2008). This highlights that cultures around risk behaviour may be country specific and differ from that of British youth, for example, the amount that international youth may drink alcohol on a weekend. For that reason, young international travellers to Liverpool may have been more likely to behave differently or take part in behaviour out of the ordinary whilst in the city. This would fit with theoretical ideas of 'liminoid' behaviour (Turner, 1982) as young international tourists enter a

leisure space away from responsibilities and structure at home that may normally dictate their behaviour. It must also be questioned whether the physical/geographical distance from home may have any effect on the way that young international visitors may behave as they may feel more a distance from their home life. Much like the longitudinal study of holidaymakers featured earlier, the use of qualitative methods may have benefited the data in the consideration of the application of theoretical concepts of risk. For example, young international and national travellers could have been interviewed to gain a deeper perspective of why they may have taken part in such risk behaviours in Liverpool, and if this was indeed city or space specific. With only the use of statistical data it is difficult to come to any conclusions about the way that norms and behaviours are affected, and the actual perceptions of the individuals involved around risk.

After the first few scoping visits to the hostels, it became clear that a substantial percentage of the visitors to Liverpool were from other cities within the UK, such as Newcastle, Belfast and Leeds. For that reason, it was decided that the questionnaires would be distributed to national visitors as well as international travellers, in order to try to provide comparative data on behaviours within different nationalities. As the study failed to generate a substantial amount of data, the national visitor surveys were included in the overall data. However, this may have been disadvantageous in diverging from the original study proposal (from the design airport study) of using only international traveller data. Nevertheless, it provided data from which to form a basic comparative analysis. Findings on national visitors to Liverpool are specifically of interest due to the high volume of UK based 'stag' and 'hen' parties present in the hostels that were studied. Stag and hen parties in general have the intention of providing an excessive and one-off experience for the group, typically involving the consumption of large amounts of alcohol (Bell, 2008; Eldridge & Roberts, 2008a, 2008b; Thurnell-Read, 2011). UK stag and hen parties have been found to seek out certain types of

performance behaviours that differ from other tourists in holiday destinations, such as dressing up in fancy dress, putting on a public show and being generally loud and boisterous (Eldridge & Roberts, 2008a, 2008b; Thurnell-Read, 2011). Stag and hen parties have been viewed as a ritual window for sexual freedom and abandoned inhibition for ‘one last time’, characterised by sexualised games and visits to strip clubs (Boazman, 2010; Montemurro, 2003; Montemurro & McClure, 2005). In which case, this can be seen as a ritual process in which an individual transitions from being free and uninhibited, to being part of a marriage union with its own set of structures and expectations, therefore the stag or hen party is the transitional stage whereby rules and norms may be suspended (Van Gennep, 1960). British stag parties in particular have been highlighted as groups that are likely to engage in sex with prostitutes (Boazman, 2010). Yet, many stag and hen parties may have not wanted to disclose their sexual activity during this time, as many would say ‘what happens in Liverpool, stays in Liverpool’. Therefore, this type of city break tourist will have a particular set of expectations of the types of behaviour they wish to take part in during their stay, such as risky casual sex and drunkenness. This can serve to separate them from other types of tourists visiting cities like Liverpool, as their intentions for their trip may be very different. This leads to the question of how future studies may be able to differentiate such populations from regular tourists when sampling; and also brings into question the motivations for city breaks in UK travellers compared to other nationalities.

Previous studies have found variations in nightlife behaviours between travellers from different nationalities visiting the Balearics, looking specifically at levels of violence (Hughes et al., 2008) and risky sexual behaviour (Downing et al., 2010). Both studies included travellers from the UK, Germany and Spain, and it was found that reported drunkenness was highest in British tourists and lowest in Spanish tourists, with German tourists reporting the lowest levels of substance use (Hughes et al., 2008). Similarly, findings showed that British

and German tourists were more likely to visit bars and nightclubs than Spanish tourists (Downing et al., 2010). Such differences in the drinking and substance using habits of different nationalities must be taken into consideration for future comparative research. For that reason, the study may have benefited from more targeted sampling of particular nationalities; as was initially planned. A similar framework used in the previous studies of different nationalities would have lent itself well to this type of study in Liverpool, and would have allowed for comparisons to be drawn between the findings of these previous studies. Nevertheless, with the absence of an airport based study, this type of sampling proved difficult. Individuals from a wide range of nationalities both in and outside of Europe were present at hostels in Liverpool; therefore, without collecting data from a very large sample, it was not possible to draw general findings from each population by country.

This also raises the question of using a hostel as a location for such research as the types of visitors using these facilities can be varied, ranging from party populations seeking cheap accommodation, to informed travellers seeking touristic exploits. Hostels can be used as a means of socialisation for many, in particular the backpacking population who rely on such locations from which to meet new people and travelling companions. Previous studies have used hostels as a location to collect data on substance use and sexual behaviour, most prominently in backpacker populations in Australia (Bellis et al., 2007; Egan, 2001; Hughes et al., 2009). This type of convenience sampling has been used to access high numbers of participants in specific areas where they are most likely to all fit the inclusion criteria of being an international traveller/backpacker. Yet the UK may differ from Australia in terms of it not being such a popular backpacker destination, and consequently the hostels included in the study housed a variation of travellers of all ages and travelling purposes. Similarly, UK hostels offer cheap accommodation in nightlife orientated cities to national travellers seeking budget accommodation for large groups, such as stag and hen parties. The purpose for travel

itself has a direct effect on the types of behaviour that the traveller will engage in, particularly around the use of alcohol and drugs, and their involvement in risky sexual behaviour. In retrospect, the questionnaire may have benefited from a section about participants' specific purpose of travel, to accompany the question of why they chose Liverpool as a destination. This again would allow for the differentiation between stag and hen tourists and others.

The study measured the sexual behaviour of participants visiting Liverpool, yet this also brought into question the use of hostels for participant recruitment instead of, for example hotels or holiday apartments, due to their restrictive nature for sexual activity with rooms often being shared with multiple people, commonly including strangers. This may have served to limit the amount of sexual encounters that participants had during their stay in Liverpool. Only a third (34.5%) of participants had sex whilst in Liverpool. Nevertheless, the findings did show that visitors had more sexual partners per week in Liverpool than at home, with the mean number of partners rising from 0.03 to 0.39. Surprisingly, there was a higher proportion of international travellers that had sex (40.3%) than national visitors (23.7%), which was an interesting finding due to the number of stag and hen parties present in hostels.

Of participants who had sex during their stay ($n=38$), 28% had unprotected sex and 16.0% had regrettable sex. Additionally, participants who had consumed alcohol were more likely to have had sex. The frequency of alcohol use reported by participants whilst in Liverpool, and the large number of bars and nightclubs in Liverpool, may serve to facilitate such alcohol induced sexual encounters. Although there were no significant links between sexual behaviour and levels of drunkenness, this may have been because of the small sample size. Such links were identified in the previous study of casual workers in Ibiza; for that reason, I can only hypothesise that such findings would be identified should the sample size have been more substantial. Similarly, like the Ibiza findings, the length of stay of participants was found to be an indicator for having sex and having multiple sexual partners. Although the

mean total length of stay in Liverpool was measured as 19.2 days, around a third of participants (31.8%) had only been there one to two days at the time of the survey. Therefore should their sexual behaviour have been measured at the end of their total stay, such participants may have disclosed a greater amount of sexual activity.

The surveys were mainly distributed at the end of the weekend (e.g. Sunday and Monday) to capture the most amounts of visitors that were due to leave after their stay, and capture the behaviours of short weekend visitors in particular. However, in applying this method it may have discounted the substance use and sexual behaviours of participants that were due to stay for a longer period in Liverpool. For that reason, such participants could have been re-approached on the final day of their holiday. Nonetheless, this would have involved a great deal more organising and delivery of surveys than the research would allow at that time. It may also have involved chasing up participants and arranging to locate them individually at a particular time that was suitable for them, which would have not proved the most effective method of capturing large amounts of data over a short time frame. For that reason, the study would have benefited from a larger team of researchers working in different hostel locations at the same time.

Part of the purpose of studying the behaviours of young visitors to the UK was to try and measure the utilisation of health services in Liverpool, to identify any gaps within service provisions that are targeted specifically for travellers, and to explore if city break travellers differ in their health seeking behaviours to other types of traveller. Unfortunately, due to sample size, the study was unable to produce any meaningful data into the use of health services in Liverpool. Only a small proportion of participants sought any healthcare, with 5.8% reporting that they visited a doctor or hospital, and only 6.4% receiving any healthcare literature or advice. It was noted that each hostel location had leaflets visible on tables and reception desks within the entrance areas, yet it was unclear at how successfully they were

distributed or acknowledged by travellers. The study did not collect a substantial amount of data on the utilisation of health services or health information, yet future research would benefit from including these issues within substance use and sexual health related studies.

The nature of some of the subjects covered by the questionnaire were sensitive, including questions about individuals' sexual behaviour and use of illicit substances. Individuals may have been apprehensive about answering questions due to the illegality of some substances listed in the questionnaire and common deviant associations with types of sexual behaviour, for example, the number of sexual partners a person may have had. Similarly, with the inclusion of young international tourists comes a variety of cultural and religious beliefs that needed to be taken into consideration which may have hindered the levels of recruitment and completion of questionnaires. To overcome this, all participants were informed of the complete anonymity of the questionnaire and were encouraged to fill in the questionnaire privately on their own. Participants were also told about their right to withdraw from the study at any point.

Communication barriers may have hindered the amount of information collected from international participants. The questionnaires were translated into formal versions in languages (English, French, Spanish, Dutch and German), however when participants required spoken communication this proved difficult as the researcher spoke only English. Moreover, the translations of the surveys may not have been exact, and mistakes may have been present, changing the understanding and context of questions. To overcome this, help was sought from individuals in the area who were able to translate, which may have limited the privacy of the questionnaire process. In hindsight researchers who spoke a number of languages fluently could have been utilised with further planning.

The hostel atmosphere may have additionally contributed to the influence of peers when filling in surveys within the reception and dining areas due to potential participants often

being part of groups gathered in these small spaces. To overcome this, individuals were asked to step away from their group in order to fill in the questionnaire privately. Participants were also asked to contact only a researcher should they require any assistance.

The design and location of the study in hostel locations was restrictive as it only allowed for the collection of data from travellers staying at each particular venue. To access a wider range of international travellers, aside from the airport, the only viable method would have been to use street based surveying. However, as a sole researcher it proved difficult to recruit temporary research staff to assist with the distribution of surveys with such short notice over the summer period. Similarly, a restrictive aspect of using hostels to complete the study was the necessity to capture the behaviours of participants who were at the end of their stay in Liverpool. For that reason surveys could only take place on a morning around the time participants were ‘checking-out’ of the hostels. This typically coincided with the serving of breakfast, which often meant that participants were either distracted or felt it was ‘too early’ to be completing a questionnaire of this nature. This limited the amount of time that could be usefully spent in the hostel in order to use time efficiently and collect a substantial amount of data over the short summer period.

The inclusion of national tourists as participants may have had the potential to skew the results due to the fact that this group has typically more excessive drinking and drug behaviours than groups from outside of the UK (Bellis et al., 2008; Hughes et al., 2011). Commonly young people from around the UK visit Liverpool for events such as ‘stag’ and ‘hen’ parties, which traditionally are heavily alcohol based and involve visiting a large number of bars and nightclubs in a short period of time. For this reason, national participants have been analysed both combined with and separate from other international participants in order to highlight any differences between groups.

One of the main barriers faced in collecting data was the presence of intoxicated individuals within the hostels, particularly young groups from the UK. To guarantee that all questionnaires were filled in correctly and honestly, and to ensure the safety of researchers and participants, individuals who appeared to be intoxicated were excluded from the study and were not approached at any point.

Liverpool played host to a number of events over the study period, including outdoor music festivals and marathons. Consequently, the type of young tourist changed over these periods and their reasons for visiting Liverpool and their involvement in risk behaviours varied accordingly. With this in mind, the initial planned study period (2 months) was extended to include an extra month (3 months in total) in order to measure an adequate spread of general behaviour on weekend periods where no events were scheduled.

6.5. Conclusion

The overarching aim of the thesis was to study different tourist risk behaviours in varied contexts to gather an evidence base for more tailored approaches to harm reduction. The original research question (4) was '*what risk and health seeking behaviours are exhibited by young travellers visiting a UK city break destination?*', and in collecting such data this question has been answered for that specific period of time. The study has also contributed towards a gap in knowledge of the health risk behaviours of young tourists that take part in city break vacations in general. Moreover, much like in previous literature it has tentatively identified stag and hen tourists as a particularly risky sub-group in nightlife settings that require further study (e.g. Thurnell-Read, 2011; 2012). Yet such groups cannot be exclusively linked to city break destinations as this type of tourism can take place in places like beach

resorts. Nevertheless, much like the longitudinal study (Chapter 3), there are not enough data to make sufficient theoretical claims about city break tourists' behaviours in general.

At the same time the study has exemplified the difficulties in collecting data in city break locations, and brings into question the most appropriate sampling sites. It can only be speculated that if the airport survey method had gone ahead a larger amount of data would have been obtained enabling more significant findings. However, at this stage one of the most important points to be taken from the study is that there may be limitations in using hostel locations in the UK. Therefore, the main outcome of this study is that there is a need to develop methods that are suitable for capturing the health related behaviours of 'city break' tourists in greater detail.

As the city break tourism industry continues to grow, more international travellers will be expected to arrive in the UK to visit major cities, such as Liverpool. Such travellers may have the intention to take part in local nightlife activities, such as binge drinking and using illicit substances. Findings have shown that the frequency of use of substances increased while in Liverpool. This increased nightlife activity and substance use has the potential to put pressure on local health services and police services. Liverpool-based studies have already found that a main predictor of violence and risky sexual behaviour in nightlife settings is excessive alcohol use (Hughes et al., 2008; Luke et al., 2002). Although the study did not uncover any significant findings on the utilisation of health services or participants involvement in violence, this may have been due to a small sample size. For that reason, further investigation would be useful to explore international travellers' health treatment behaviours.

Chapter 7: Final discussion of thesis

Final discussion of thesis

The thesis set out to study the substance use and sexual behaviours of young travellers in international tourist destinations, and to identify their specific health needs. The over-arching *aims* of the thesis were to:-

- Explore the substance use and sexual risk behaviours of different types of young tourist populations in varying tourism destinations;
- Examine the utilisation of health services and health needs of tourist populations within differing tourist environments to identify gaps in service provision;
- Contribute to an evidence base for tailored health literature and services that are contextually appropriate.

The *objectives* of the thesis were to:

- (a) Review current literature on youth tourism and risk behaviours and identify gaps in research to be explored, focusing particularly on substance use, sexual health and utilisation of health services in nightlife orientated resorts;
- (b) Explore methodologies that have been previously used to measure risk behaviours in holiday destinations;
- (c) Identify a high risk population of young British tourists (casual workers) in a nightlife orientated resort and use mixed methods (quantitative and ethnographic) to measure and describe their levels of risk behaviour around substance use and sexual activity and their utilisation of existing health services;

- (d) Trial a method of identifying the impact of holiday risk-taking behaviours on young people's longer-term risk taking by implementing a three-stage longitudinal quantitative study among general holidaymakers to measure risk behaviours before, during and after the holiday;
- (e) Measure the risk taking behaviours of young tourists visiting the UK as a city break destination by implementing a short quantitative study among national and international visitors to Liverpool, examining levels of substance use, sexual behaviour and utilisation of existing health services;

Following this, the *research questions* formulated were:

1. What risk and health seeking behaviours are exhibited by young casual workers in an international nightlife resort?
2. What are the everyday behavioural norms and experiences of casual workers that may affect involvement in risk behaviours and use of health services?
3. What changes in levels of individuals' risk and health seeking behaviours take place pre, during and post-travel?
4. What risk and health-seeking behaviours are exhibited by young travellers visiting a UK city break destination?

Building on the literature review, the individual objectives were set based upon the aims to allow for development of a comprehensive study that filled gaps in knowledge on youth tourism and risk behaviour. Although there are many existing studies on tourists that visit beach holiday resorts, it was identified that there was a lack of literature on other types of tourists and destination types. For that reason, there was a need to study other traveller groups and destination types, such as casual workers and city break tourists. Most previous studies were quantitative, and there was a scarcity of detailed qualitative enquiries that explored in-

depth why risk behaviours took place, looking at social, cultural and environmental factors. Longitudinal studies were in existence, yet no study had followed the whole tourist pathway from the beginning to the end of the holiday period, and the effect that time spent on holiday may have on behaviours on return home. Finally, it was found that studies had yet to measure the utilisation of health services in holiday destinations by visiting tourists, which is vital for understanding individuals' health seeking behaviours and the potential for the delivery of tailored health services. Ultimately, what was most evident from the existing literature was that there is a need to understand the importance of context and type when it comes to the delivery of harm reduction measures for tourists. Without such information, health interventions may not be adequately applied in holiday destinations where there are particularly high levels of risk behaviour taking place. In order to facilitate tailored health approaches, evidence was needed to support the fact that health and policy procedures cannot be a 'one size fits all'.

The following discussion will firstly provide a brief summary of the findings from each of the studies featured in the thesis. Secondly, the limitations of the findings will be discussed in light of the previously identified gaps in literature and overarching aims of the thesis. Thirdly, the conclusion will discuss the theoretical implications of the thesis in relation to previously investigated concepts. Further to this, the implications for policy will be explored and lastly some recommendations for future research will be made.

1. Ibiza casual workers study

The thesis firstly explored a population of young casual workers in Ibiza, with the intention of measuring the behaviour of a particularly high-risk population in a notoriously hedonistic holiday resort. The study was two-fold, using both a quantitative survey and ethnographic

fieldwork in order to provide a more holistic view of this risk sub-group. To summarise, the main findings were as follows:-

(a) Casual workers were consuming a high level of illicit substances in Ibiza and there was a significant level of recruitment to drug use, particularly in first time casual workers who were new to the island and influenced by peer pressure.

(b) Casual workers were regularly consuming high levels of alcohol both in and out of the work place, with around three quarters of participants reporting using alcohol five or more times a week.

(c) Casual workers were taking part in high levels of risky sexual behaviour with alcohol being found as a significant factor for instances of risky and regrettable sexual behaviour. Sexual encounters are also found to be facilitated within the work place.

(d) Casual workers reported having a higher mean number of sexual partners per fortnight whilst in Ibiza compared to previously at home in the UK.

(e) Casual workers were getting involved in drug dealing activities due to a lack of income and employment, and as a result of the normalisation/decriminalisation of drug use within the population.

(f) There were many barriers to accessing healthcare in Ibiza, such as cost, trustworthiness of services, and individuals' prioritisation of their health.

The study met its objectives in identifying a particularly high-risk tourist group in one of the most notorious nightlife orientated resorts in the world, and measuring and describing their sexual and substance use behaviours and their utilisation of health services. It also answered the research questions in understanding the risk and health seeking behaviours of young casual workers, and exploring the everyday behavioural norms and experiences that may have involved their involvement in risk activities.

The study of Ibiza casual workers could be viewed to be more in-depth than the other two studies because of its use of both quantitative and ethnographic methods combined. However, the results of the survey and the ethnographic study stand alone as examples of how casual workers are taking part in risk behaviours that are conducive of short and long-term health problems. Such findings contribute to our understanding of the behaviours of an extreme case of working holiday-makers, who have been identified in literature as simply long term tourists. In taking a sample of casual workers from one of the most notorious drug/dance music associated nightlife resorts in the world, this allows for a basis of comparison to other resorts and traveller types, both similar and different. It could be said that if effective health interventions can be successfully introduced in a place like San Antonio, Ibiza, they can be introduced in any similar resort. Yet, what is most important is that casual workers have been identified as having different patterns of risk behaviour to non-working short-term tourists, particularly in the way that they inhabit resorts for longer periods. It has to be considered that casual workers require different types of health messages that are more suited to their behaviours, and should be treated as a group separate to other tourists. It could be criticised that casual workers are only a small and niche group of travellers, yet what must be considered is that casual workers evidently set certain social norms and boundaries in Ibiza. Thus, they have the potential to influence the behaviour of tourists that they come into contact with; for example, in promoting excessive alcohol use or selling drugs to tourists. Therefore, casual workers could be well placed to both set an example to regular tourists visiting such destinations, and deliver appropriate health messages. Nevertheless, this is dependent on the extent to which tourists are passive recipients within nightlife arenas, and whether they might actually view casual workers as role models. In targeting such a group, this may actually be more of a grassroots level intervention for wider tourist visitors and other casual workers in the future.

As well as exploring the sexual behaviour and substance use of casual workers as a particular type of tourist, the study also contributes to the aims of the thesis in examining in detail the health services that were available to casual workers in Ibiza at that time. This not only gave a view of why casual workers are not using health services, but also gave a snapshot of what type of services may exist in similar resorts of this kind, especially in the prominence of private and costly healthcare clinics. This offers a glimpse of the barriers that stakeholders, such as policymakers or the Foreign Office, may be facing when attempting to implement accessible services for tourists.

2. The longitudinal holidaymakers study

Secondly the thesis trialled the use of a novel three-stage longitudinal analysis to measure changes in the behaviours of tourists visiting different destinations, using a series of online surveys before, during and after the holiday. The study set out to both test the effectiveness of such an approach, and to capture data on different tourist types visiting various holiday destinations. However, using a three-stage longitudinal study resulted in high dropout rates, leaving a sample that was not large enough to extrapolate any meaningful data on their full holiday pathway.

The main findings of this study were as follows:-

- (a) Participants' bar and nightclub attendance increased during the holiday period compared to pre and post-holiday.
- (b) Substance use decreased whilst on holiday compared to pre and post-holiday use across all illicit substances.
- (c) The frequency of alcohol use increased significantly during the holiday period, compared to pre and post-holiday.

- (d) The average number of sexual partners per week increased during the holiday period.
- (e) Only a small proportion of travellers accessed healthcare information, advice or treatment whilst on holiday, whereas a larger proportion accessed healthcare both pre and post-holiday.

This study met its objective of trialling a longitudinal method of measuring changes in risk behaviour pre, during and post-holiday, and the risk behaviours of a population were measured. However, the study did not provide a great deal of data and therefore it was only able to partially answer the research question as changes in levels of risk behaviour could not be adequately measured.

Despite the low sample size and dropout rates seen in this study, it does not mean that this method of three-stage analysis should be discounted for future research. The value of the study is that it is the first to trial a three-stage data collection technique with tourists, and such trials are needed in order to improve research practice. The limitations of the study that are discussed earlier in the study chapter (mainly sample size) have been an invaluable learning curve for myself, and are useful to inform future researchers.

In terms of this study's contribution to the aims of the thesis, it has firstly attempted to explore the sexual behaviour and substance use of a wide sample of tourists visiting a range of different destinations; and has secondly measured the participants' use of health services at each stage of their holiday pathway. Although the study has not provided a specific evidence base for tailored healthcare for tourists, I would hope that should this study be replicated with a much larger sample that these findings would emerge.

3. The Liverpool tourists' study

Thirdly, the thesis set out to measure the behaviours of young national and international tourists visiting Liverpool in the UK. The study aimed to not only study the risk behaviours of tourists visiting a UK city, but also to gather evidence for city break tourists as a specific risk group. A summary of the main findings is as follows:-

- (a) Around half of participants stated that they were visiting Liverpool specifically for the nightlife. This was particularly prevalent in visitors from other areas of the UK.
- (b) Only a small proportion of visitors used illicit drugs whilst in Liverpool, fewer than used them at home. The most commonly used drugs in Liverpool were cocaine and cannabis. Of those who used drugs, just under half were visitors from elsewhere in the UK.
- (c) Participants' frequency of alcohol use and drunkenness greatly increased whilst in Liverpool in comparison to previous reported use at home. Participants who had used alcohol were more likely to have had sex during their stay, and all participants that had unprotected sex were under the influence of alcohol at the time.
- (d) Participants reported having had a greater mean number of sexual partners per week in Liverpool compared to previously at home. Of those who had sex in Liverpool, a quarter of these participants had unprotected sex, and it was found that those in the 25-35 age group were more likely to have had unprotected sex.
- (e) Only a very small proportion of visitors to Liverpool received any healthcare advice or treatment during their stay.

This study met its objective of measuring the risk and health seeking behaviours of young travellers visiting a UK city break destination. However, like the Longitudinal Holidaymakers Study, this study too was hindered by a small sample size that did not allow for the extrapolation of rich data. The study provides a small amount of data on the sexual

behaviour, substance use and utilisation of health services by national and international travellers visiting Liverpool as a tourism destination. For that reason, the research question has not been fully answered as the data is relatively inconclusive.

As previously highlighted in the methods and discussion sections of this study's chapter, the research was affected by issues with the location of the data collection. Nevertheless, the study still contributes to the aims of the study and is novel in being the first study of its kind to study tourists visiting the UK and the first quantitative study of city break travellers as a tourist type. As highlighted in the literature review, there are some previous studies that have looked at city break tourism with an 'urban tourism' field (e.g. Davison & Ryley, 2010; Dunne et al, 2011), yet only one author has looked into the alcohol, drug and sexual related behaviour of tourists (Thurnell-Read, 2011; 2012). The research took place in Liverpool due to its locality to the university, but also as it is historically associated with dance music and substance use (much like Ibiza). As half of the participants reported visiting Liverpool specifically for its nightlife, this city should not be discounted for future research into nightlife related tourism. Therefore, the study has not necessarily provided an evidence base for tailored health messages for city break travellers, but has provided a small evidence base for city break tourists and Liverpool itself as an area of interest for nightlife related risk behaviours.

What the three studies all have in common is that firstly the frequency of alcohol use of participants increased whilst in each holiday destination. Secondly, participants in each study reported a greater mean number of sexual partners during their time spent on holiday than previously at home. Thirdly, across all studies the utilisation and access to health advice, information and treatment was very low.

Theoretical implications

The thesis set out to look at the risk behaviours of young people in varying holiday destinations, and theoretical concepts were outlined throughout in relation to each study. The ‘introduction to concepts’ section at the beginning of this thesis described a number of ideas about how people view risk, and why risk behaviours may take place.

The idea of ‘liminality’ as first coined by Van Gennep (1960) and later developed by Turner (1967) describes a period of passage from one stage to another, such as a ritual, where a person no longer holds their previous status, but has not yet adopted a new status and the individual may be in a state of transition. Van Gennep (1960) had outlined three distinct stages of liminality; separation, transition, and reincorporation, however, Turner’s work mainly focused on the middle stage of ‘transition’, stating that ‘in this gap between ordered worlds almost anything can happen’ (1974:13). Whilst focusing on this middle stage Turner (1982) later distinguished between the terms ‘liminal’- describing something that is traditional or obligatory, such as rituals and ceremonies; and ‘liminoid’- describing something non-traditional, optional and voluntary, like a passage to a leisure setting such as a holiday or creative activity. Therefore, what this thesis has covered is activity that is ‘liminoid’ rather than ‘liminal’, as it has studied the holiday as a leisure space that people choose to go to voluntarily.

As previously identified the holiday destination as a ‘liminal space’ has been studied by a number of scholars (Andrews & Roberts, 2012; Bell, 2008; Bloor et al., 1998; Graburn, 1989, 2004; Ryan, 1997; Shields, 1990; Thomas, 2005; Wickens & Sonmez, 2007), however what the first study of the thesis set out to explore was the risk behaviour of casual workers who reside in a holiday destination for a lengthier period of time than regular short-term tourists described in previous studies. What was found was that the actual process of becoming a ‘casual worker’ can be seen as a ‘rite of passage’ in itself as workers arrive in Ibiza and are

then take part in activities that are seen to initiate them into the worker society (Van Gennep, 1960). Within this transitional period, individuals are separated from responsibilities and structures at home that may have governed the way that they would previously behave, such as jobs and the influence of parents and peers. Therefore, the time spent in Ibiza is characterised by experimentation with drugs, excessive alcohol use and risky casual sexual encounters. This can also be related to the theoretical idea of 'situational disinhibition' whereby situational factors, such as the environment that a person may enter or the people who they are socialising with make them feel like a 'different person' and that they can do things that they might not normally do (Apostolopoulos et al., 2002; Eiser & Ford, 1995).

What is of interest is the way that casual workers may be 'reincorporated' back into life in the UK when they return, after they have spent the summer becoming a 'casual worker' and living as such for a lengthy period of time. As individuals have been separated from routine space and structures at home, it is questionable whether they would return to a 'post liminoid' state as described by Graburn (1989) where they may return to their ordinary state as before their time spent in Ibiza. On the other hand, casual workers may return to the UK with a different set of social norms and values around risk behaviour that may continue after their time spent abroad. Nevertheless, the liminal period does not necessarily have to be characterised by a person transforming or changing, as an individual can be reincorporated into home life as they once were. The longitudinal holidaymakers study set out to study this phenomenon further by looking at participation in risk behaviours before, during and after periods of time spent in a holiday destination.

The Longitudinal Holidaymakers study used a sample of holidaymakers travelling to a number of different destinations, and the sample after the dropout rate at each stage was reasonably small. For that reason, although it could be said that the holidaymakers involved in the study may have entered a 'liminoid' space, it is unclear whether their behaviour was

affected as a result from being separated from structures and responsibilities at home. This was because the sample was not a big enough size to draw any significant conclusions, and it was not clear what were the motivations and expectations for each person's holiday. For example, some travellers may have been going to a holiday destination to visit friends or family, therefore seeking a type of familiarity, rather than behaviour out of the ordinary. Additionally, the findings did not show any significant changes in people's behaviour when they returned from their time spent on holiday in terms of alcohol use, drug use or sexual behaviour. Therefore, the study did not allow for speculations about the 'reincorporation' stage of the liminal period of a holiday, and how participants may have been affected or changed by their time spent away.

Much like this study, the Liverpool Tourists study also had a small sample, however, this was made up of both international and national travellers visiting a UK city break destination. When thinking about risk behaviour this led to a number of questions around the application of theoretical concepts. For example, would a national visitor from another UK city be taking part in any behaviours that would necessarily differ from that at home? This was reflected in the findings with some participants drinking less alcohol and taking less drugs whilst in Liverpool compared to what they may have previously at home on a weekend. Similarly, the cultural differences between different international travellers may also have meant that some didn't consume alcohol or attend bars and nightclubs at all during their stay.

The Ibiza casual workers study provided a lot of data in which theoretical understandings of risk behaviour could be drawn, however the study benefited from the use of ethnographic data that allowed for a deeper exploration of the study population. Without the use of such methods in the Longitudinal and Liverpool studies, coupled with the small sample size, it is clear that the theoretical conclusions can only be drawn from the Ibiza study as a lone piece of research.

The idea of ‘risk’ that is described in this thesis relates to people’s perceptions of risk and their motivations for taking part in risky behaviours. Individuals may perceive that the risk to them is less if everyone else around them is doing the same thing. Casual workers in Ibiza may perceive the risk of taking an ecstasy pill as less because all of their friends may have used or be using this substance, and the pill may have been purchased by someone they know and trust. In the same way, casual workers were found to consume particular substances as a way to keep them awake for long periods of time to help with their working hours, therefore the motivation for use was not always recreational.

Young people may be choosing their holiday destination based on access to activities that may be deemed ‘risky’, such as thrill seekers who want to take part in a bungee jump, or take a new substance they have never tried. They may also choose their holiday destination built on images built in the media; with places like Ibiza being portrayed as hedonistic party destinations. The influence of peers can also be seen to affect the level to which young people may take part in risk behaviours whilst on holiday; this was shown in the way that first time workers were coerced by seasoned workers to ‘drop their first pill’ to become an initiated casual worker. Therefore, status and achievement can often be attached to risk in such environments. Ultimately, risk and knowledge about risk can be complex concepts that are affected by a number of different variables, therefore it is difficult to homogenise groups of tourists in understanding their behaviours. However, this thesis, particularly the study of young British casual workers in Ibiza, has contributed to a better understanding of how risk environments flourish and how individual’s norms and attitudes around participation in risk activities can be shaped by such environments and levels of socialisation with other risk takers.

Policy and healthcare implications

What this thesis has aimed to do is build an evidence base for tailored health information, advice and treatment for different tourist types in different destinations, such as casual workers and city break tourists. Although the evidence can be seen as somewhat inconclusive in the case of city break tourism, there is definitely a case for the recognition of casual workers as a particular high-risk sub-group of tourists that require specialised targeting.

As highlighted in Chapter 4, casual workers could be targeted in such a way to educate them on the risk in taking part in casual work in destinations like Ibiza. Most importantly, information should be available about the risks of excessive alcohol use, substance use and sexual behaviour. Additionally, casual workers need a better awareness of the health services that are available to them, and how much this will cost. Yet messages would also be appropriate about homelessness, income and nutrition.

Nevertheless, the problems may lie in the fact that parties do not have a vested interest in the healthcare of travellers and there are no existing policies that deal with issues of risk of travellers outside of home countries. Travellers who are involved in alcohol-related illness or injury in a foreign country, for example, may not be of importance to authorities back at home. Yet, in the same way, the delivery of specific healthcare for travellers is neither a priority for local health authorities within foreign countries. At the same time, it has to be questioned why Spanish authorities should take responsibility for British visitors, and why UK authorities should take notice of risk activities occurring outside of the country. Yet without a solution this leaves casual workers in healthcare limbo. However, research like the casual workers study has highlighted the importance of the provision of services for at risk groups; not only to reduce risk behaviour, but also to decrease the burden on local health services and those back at home. As much of this behaviour is self-inflicted, there are issues around personal responsibility, therefore it could be said that this should lie with tourists and

casual workers to take better care of themselves and avoid risk behaviours. Yet when looking at a more upstream approach the answer may lie in the way that risk environments are in existence that promote behaviours like excessive alcohol use. For example, in Ibiza there are resorts like San Antonio, that are design to cater for holidaymakers who want to take part in hedonistic pursuits, with strategically placed bars and nightclubs and continual cheap drink offers. If the actual risk environments could be controlled and regulated, such as introducing minimum alcohol pricing or stricter licensing laws on the sale of specific spirit measures, this could potentially decrease incidents of binge drinking amongst tourists. Similarly, it could be argued that if destinations, such as Ibiza, are providing the means to take part in risk behaviours that may result in illness or injury, then they should provide healthcare to deal with these consequences. Yet, as casual workers and other tourists studied in this thesis are technically classed as adults, we must question their ability to make informed decisions about their participation in risk behaviour and utilisation of health services.

There is a potentially long list of stakeholders that would have a vested interest in the delivery of healthcare to young travellers in nightlife related destinations, and if parties were to work together then some short and long term solutions could be generated:-

- *Holiday companies that sell package holidays to tourists or flights and accommodation to casual workers*
- *Local health authorities and services existing in holiday destinations*
- *National health authorities/services who are involved in policy in host and home countries*
- *The Foreign Office within host countries*
- *Local and national criminal justice authorities*
- *Tourists*
- *Casual workers*

- *Non-Governmental Organisations (NGOs) e.g. charities, social enterprise*
- *Bar and nightclubs owners and staff*

Holiday companies are placed at the stage where they can deliver specifics warning and literature to those who are booking holidays from the onset. Although individuals may not book a full package holiday (including flights, accommodation and activities), they may still use a holiday company to book separate flights or a hotel, therefore may come into contact with such service providers at some stage. However, current distribution of health literature and health messages only occurs when tourists book a full package holiday and are accompanied by holiday reps throughout their stay. Moreover, there is no consideration of those who seek private accommodation. Therefore, an option may be to involve flight operators in the distribution of health messages to ensure that tourists are being reached. This is especially relevant as booking flights and accommodation separately is now commonplace as it can be much cheaper, and there are many search engines that dominate internet bookings in the UK, such as ‘skyscanner.net’ and ‘booking.com’ offering cut price flights and hotels.

The NHS in the UK produces a large amount of literature every year with health warnings, including to travellers. Yet the role that health authorities in both the UK and destination countries could play would be in the delivery of tailored health messages for specific holiday types/ destinations both pre-travel and on the ground within local health services in holiday destinations.

The Foreign Office in particular, is very well placed to deliver information to travellers that is specific to substance use, sexual behaviour and available health services in holiday destinations. For example, the current Foreign Office webpages (2015/6) for travelling to Spain offer safety guidance on specific events in Spain, such as bull-running and football games, yet fail to offer any guidance on public health related matters or available health services. If the webpage is able to go into such detail regarding specific one-day events, they

should then be able to provide tailored advice and information for specific traveller groups such as youth package holiday tourists and casual workers. Nonetheless, Spain could be considered as a 'safe' and low risk destination for travellers, compared to other high-risk countries that are affected by war or disease, therefore not a specific priority for harm reduction.

Local and national criminal justice authorities are an important stakeholder in harm reduction measures for young travellers, in particular with the deterrence of use of illicit substances and findings ways to prevent drug industries from thriving within holiday resorts. At the same time, and as shown in the literature review, if excessive alcohol and drug use is leading to instances of violence and anti-social behaviour within holiday destinations, then local authorities should have a vested interest in the reduction of such crimes. Similarly, local and national authorities have a responsibility to tackle alcohol problems related to the environment and infrastructure of the nightlife economy.

The ethnographic study in particular has highlighted that speaking to and spending time with casual workers is an effective way of understanding why risks occur and how deviant behaviour becomes normalised. Therefore, it is vital that both tourists and casual workers are consulted in the delivery of harm reduction measures that are appropriate for different traveller types within different destinations. This is especially relevant if casual workers are to be considered as key mediators of health messages and for the setting of social norms for tourists.

Studying an NGO like Ibiza 24/7 in San Antonio has allowed for an understanding of the role such organisations can play in the delivery of tailored health and safety messages, and emotional support and assistance in holiday resorts. This type of grassroots level is particularly beneficial due to the amount of on the ground contact that these organisations have with travellers on an everyday basis, therefore being able to be flexible and responsive

to meeting travellers' needs. Yet, NGOs may struggle with both funding and taking on a large responsibility, as shown by Ibiza 24/7. Similarly, setting up an NGO to help drunk and disorderly people in holiday nightlife destinations may not be seen as a vital or desirable service as the problems created are self-inflicted and avoidable.

As this thesis has looked specifically at nightlife related holiday destinations, it is important to include bar and nightclub staff and owners in prevention. Such groups are responsible for not only providing individuals with alcohol, but also for adhering to licensing and safety limits for patrons; for example, being proactive about not serving intoxicated individuals, or the prevention of drug use on their premises. An example of good practice is in the way that Ibiza-24/7 had regular contact with bar owners via radio/ walky-talky to quickly respond to incidents in and around bar areas. If bar and nightclub owners can promote more sensible drinking practices in holiday destinations, for example cutting down or eliminating binge drinking offers, then this may have a direct effect on the amount of alcohol related illness, injury and violence that occurs within resorts. Yet, bar and nightclub owners may be in a juxtaposition of only having a short amount of time (e.g. over the summer season) to make money, therefore rely on alcohol promotions and people drinking to excess. Additionally, the control of alcohol pricing may only be implemented by policymakers setting legislations. An example of recent implementation of such policy has been shown in England and Wales with a ban on the sale of alcohol below the cost of duty plus VAT (since May 2014), to encourage suppliers of alcohol to be more responsible about their sales (Home Office, 2015).

Taking all of these stakeholders into consideration, it may be a difficult task to engage with all groups at the same time, however, as researchers it is important that all groups are consulted to provide evidence for what may actually work in terms of harm reduction.

Recommendations for future research

The thesis set out to look at different tourists types in a number of different contexts, yet what the study did not necessarily do was look at differences in gender between risk behaviours; having only the specification of looking at young people between the ages of 16-35. The reason for this was that it was hoped that in collecting a large amount of data that potential differences between genders may be found within the data, however these were not apparent as both genders typically acted the same way. As well as previous studies looking at single sex behaviours (e.g. Thomas 2005, looked at the sexual behaviour of females in Tenerife), there are also a few very recent studies that have looked into single sex behaviour (e.g. Berdychevsky et al., 2015; Theocharous et al., 2015). Yet there are still no studies that have set out to look particularly at the differences between gender and risk behaviour on holiday. As the quantitative studies within this thesis did not necessarily uncover any differences between genders for risk behaviour, it may be more appropriate in future to use qualitative methods, such as ethnography, to study the subtler nuanced differences in gender behaviour that may not be apparent within numerical measurement. Such small differences have been identified by Briggs et al, (2011a) in a previous ethnographic study of young people's sexual behaviour in Ibiza, whereby males were more forthcoming in disclosing information about their sexual activity than females. For that reason, future research would benefit from using ethnographic techniques to tease out factors related to gender.

The study of Ibiza casual workers provided data on the high levels of recruitment of young people to drug use and drug dealing activity during their stay in the resort of San Antonio. It has been highlighted that this is of concern for when the casual workers return home, as such normalisation of drug activity in Ibiza may turn into a habit or occupation back in the UK. For that reason, it would be effective to adopt the three-stage longitudinal methods used on the general holidaymaker population to the measurement of risk behaviour in casual workers.

This would enable the measurement of continued drug use and drug dealing activity on return home. It may also potentially uncover the burden that such behaviour has on UK health services and police authorities. As the casual workers study uncovered other such risk behaviour, like excessive alcohol use and risky sexual behaviour, this type of study could also capture how this affects their use of alcohol and sexual activity when back at home. Similarly, if Ibiza is to be viewed as a liminal environment where norms and values are temporarily suspended, it would be useful to see if these normal social codes return when casual workers return home to the 'post liminal' period.

Each of the studies showed a low level of use of health services within holiday destinations. Although the ethnographic study of casual workers in Ibiza uncovered reasons behind non-use of services, such as lack of trust and cost, it would be useful to engage with the actual health service staff in holiday destinations on a greater level to study how they feel about the burden on their services. If holiday service staff and local health authorities are to be seen as stakeholders in the delivery of harm reduction interventions for young tourists, it is vital to gain a deeper understanding of their resources and funding, as well as their views on how services are ran currently.

As discussed, the Longitudinal Holidaymaker Study and the Liverpool Tourists' Study did not generate the amount of data that was needed to extrapolate any meaningful data, which has been described in each chapter. Therefore, it would be useful to repeat the same studies trialling different methods of data collection and sampling. In particular, I still believe that the Liverpool Tourist Study would have been more successful should access to the airport have been granted for data collection. For that reason, I would strive to replicate this study within that environment in other areas of the UK that are popular for visiting tourists from other countries.

Finally, as previously highlighted, it could be said that casual workers are ideally placed to

deliver harm reduction messages to tourists and to set example behaviour. Yet this study did not look at the relationships between casual workers and tourists, and little is known about this dynamic. Tourists may not necessarily be passive recipients of health messages and may not view casual workers as role models. A recent review of literature looked at factors influencing sexual behaviour between tourists and tourism workers in holiday destinations (Simkhada et al., 2016). This paper exemplified that a greater understanding is needed of sexual health risk amongst such groups. Without such information, it is not clear if casual workers would be effective in a role of risk mediator, therefore further studies are needed to uncover such relationships.

Concluding remarks

This piece of research contributes towards a field of knowledge in the field of public health and tourism about nightlife, substance use, sexual behaviour, and the utilisation of health services of young tourists in holiday destinations. The objectives of the study were all met, and where some did not meet expectations, others far advanced them, especially in terms of the Ibiza casual workers study.

The thesis has provided data that was missing on important topics such as the utilisation of health services in holiday destinations and provided more in depth explorations of the way that attitudes to risk behaviour in holiday destinations are formed. The research has also given unexpected insights into traveller behaviour, such as drug dealing activity in Ibiza; all of which can be used to inform future research, and provide important information for the implementation of harm reduction messages. Such information can be used to educate young people about the specific contextual risks that are apparent in different travel destinations, and also to inform young people of where they can (or cannot) access the necessary

healthcare that they might require.

Although the study findings were reasonably inconclusive for both the Longitudinal Holidaymakers study and the Liverpool Tourists study, it is hoped that the data collected and the methods used can be used to inform future research into these areas. This is especially important, firstly, as little is known about the effect that being on holiday may have on people's behaviours and attitudes towards risk behaviour when they return home compared with their behaviour previously at home. Within policy it has not yet been clearly acknowledged that holiday environments may be breeding grounds for public health concerns such as substance addiction and the spread of sexually transmitted diseases. Secondly, the thesis has shown that UK city break destinations can be places where tourists would visit to specifically take part in behaviours such as excessive alcohol use, yet it is still unclear whether there are adequate health messages and services available for the international visitor. Therefore, there are clearly still areas that require further in-depth exploration.

The thesis has also explored the way that risk perceptions are formed within population of working holiday-makers, and the motivations behind their involvement in risk activities. In which case it is important to apply such understandings to the way that health messages and services are contextually tailored to both reach and be attractive to users. Where harm reduction messages may be failing is that they do not cater for the types of tourists that may be visiting destinations and the risks to their health that are specific to that destination. Ibiza is seen as a hedonistic capital associated with drug use and dance music, where substances are so inherent to the lives of casual workers, yet there are no existing harm reduction messages that warn people of the strength of ecstasy pills in Ibiza compared to those at home, for example. In the same way, Liverpool is classed as the 'alcohol capital of England', therefore tourists may be drawn to the city specifically to take part in excessive binge drinking, with its own set of health issues. Yet, it is unknown if there are any harm reduction

messages targeted to international travellers visiting this tourist city. Subsequently, it is hoped that this piece of work will contribute towards promoting the need for contextually appropriate harm reduction messages for tourists in different types of holiday locations.

In terms of my own personal experiences this thesis and the information gathered and disseminated within it has allowed me to become more knowledgeable within my field on the risk behaviours of casual workers within nightlife resorts. Most importantly in being reflexive, the thesis has taught me valuable lessons about conducting research projects, most particularly in the value of qualitative research as a complementary tool to statistics, and the importance of effective sampling. Moving forward I would very much like to stay within this field of research, measuring substance use and sexual behaviour in tourism contexts as I feel that there is still a lot of evidence to collect for the building of a case of tailored health advice and literature for tourists.

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Appendices

Appendix 1: Ibiza casual workers quantitative questionnaire

SEXUAL HEALTH IBIZA 2009

1. How old are you? 2. What is your sex? ☐ Male ☐ Female

3. What is your normal country of residence?

4. When did you arrive in Ibiza?

5. Did you: Come to Ibiza to work in a prearranged job ☐
Come to Ibiza to find work ☐
Come to Ibiza on holiday and decide to stay ☐

6. How much longer do you intend to stay in Ibiza?

Months Weeks Days

7. What work are you currently doing in Ibiza?

8. How many hours per week do you work in total?

9. How many days and/or nights per week do you usually work?

Days Nights

10. How many seasons have you worked in Ibiza before? (if this is your first season, write 0)

11. Why did you choose to work in Ibiza?

Nightlife ☐
Weather ☐
Family/Friends ☐
Sex ☐
Drugs ☐
Music ☐

Other (please specify)

12. How many nights per week do you:

Go to a bar

Visit a nightclub

Go to a house party

13. How many days, if any, per week whilst in Ibiza do you use the following substances? (please tick the appropriate boxes)

	Never	Occasionally/irregularly	Once a week	2-4 days a week	5 or more days a week	Everyday
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. While at home in the UK, how often do you normally use the substances listed below: (please tick the appropriate boxes)

	Never	Used but not in the last 12 months	Use less than once a month	Use 1-3 times a month	Use once a week	Use 2-4 days a week	Use 5 or more days a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. How many days in Ibiza per week would you say you get drunk?

16. Did you come to Ibiza with a long term partner or spouse? Yes ☐
No ☐

17. How many people have you had sex with during this stay in Ibiza?

Male
Female

18. If you had sex, how many of your partners were:

	Male	Female
Workers	<input type="text"/>	<input type="text"/>
Tourists	<input type="text"/>	<input type="text"/>
Local Residents	<input type="text"/>	<input type="text"/>
Other (please specify)	<input type="text"/>	

19. With how many of these partners did you always use a condom?

Workers	<input type="text"/>
Tourists	<input type="text"/>
Local Residents	<input type="text"/>
Other	<input type="text"/>

20. If you had unprotected sex in Ibiza, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

21. Have you had sex in Ibiza that you have later regretted? Yes ☐ No ☐

22. If yes, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

23. How many sexual partners have you had in the previous 12 months in the UK?

Appendix 1

24. Have you had sex in Ibiza with someone not from your own country of residence? Yes ☐
No ☐

25. If yes, were they:

Worker ☐
Tourist ☐
Local resident ☐
Other ☐

26. Have you had to go to the hospital or doctors during your stay in Ibiza? Yes ☐
No ☐

27. If yes, was it:

Drug Related ☐
Alcohol related ☐
Sex related ☐
Other ☐

28. While in Ibiza, have you or a partner required any of the following:

	You	Partner
Emergency Contraception	<input type="text"/>	<input type="text"/>
Sexual Health check up	<input type="text"/>	<input type="text"/>
Pregnancy Test	<input type="text"/>	<input type="text"/>

29. Whilst in Ibiza, have you received any health information on the following:

Drugs
Alcohol
Sexual health

30. Following your stay in Ibiza, do you intend to get a sexual health check up on return to the UK? Yes ☐
No ☐

Thank You

For further information on this survey contact d.kelly@liverpool.ac.uk



Appendix 2: Ethics form for Ibiza casual worker study



Research Ethics Committee Application

Application for Ethical Approval of Undergraduate, Postgraduate or Staff Research involving Human Participants or the Use of Personal Data

Where research involving human participants or databases of personal information is being conducted by a member of staff or student LJMU Research Ethics Committee (REC) considers and advises researchers on the ethical implications of their study.

No research must be started without full, unconditional ethical approval.

Applications must be made using this form and must be typed. Please note that the only valid version of this application form is the current version found online. Previous versions will not be accepted.

Guidance on completing this form can be found at
<http://www.ljmu.ac.uk/RGSO/93717.htm>

Applications, inclusive of specified attachments, can be emailed to LJMU REC via researchethics@ljmu.ac.uk. A signed paper copy must also be sent to the Research Ethics Administrator, Research Support Office, Rodney House. Applications must be received by the submission dates published on the RSO website.

Where a University research project is to be undertaken using NHS patients, staff or resources or

the work must undergo ethical review via the National Research Ethics Service (NRES). University staff or students undertaking such research need not complete this form but must submit a completed [LJMU Research Governance Proforma](#) and provide LJMU

REC with written evidence of full, unconditional ethical approval from NRES prior to commencing their research. On receiving confirmation of NRES ethical approval formal notification of LJMU REC approval will be issued via Chair's action.

Where teaching practices involve invasive (psychological or physiological) procedures on human participants staff should refer to the guidance provided at <http://www.ljmu.ac.uk/RGSO/93087.htm> regarding the development of departmental/faculty codes of practice. Codes of Practice will receive blanket approval for a period of 5 years from LJMU REC.

Potential participants must not be contacted until written approval has been received from the LJMU REC.

Application for Ethical Approval of Research Involving Human Participants

Research Mode

<input type="checkbox"/>	Undergraduate – specify course
<input type="checkbox"/>	Postgraduate
<input type="checkbox"/>	MRes,
<input checked="" type="checkbox"/>	MPhil,
<input type="checkbox"/>	PhD
<input type="checkbox"/>	Prof Doc
<input type="checkbox"/>	Other – please specify

<input type="checkbox"/>	Postdoctoral
<input type="checkbox"/>	Staff project
<input type="checkbox"/>	Other – please specify

Section A – The Applicant

A1a. Title of the Research

The sexual behaviour and sexual health needs of British casual workers in an international nightlife resort

A2. Principal Investigator (PI) (*Note that the in the case of postgraduate or undergraduate research the student is designated the PI. For research undertaken by staff inclusive of postdoctoral researchers and research assistants the staff member conducting the research is designated the PI.*)

Title Forename Surname

Post

Department / School /
Faculty

Centre for Public Health, Faculty of Health and Applied Social
Sciences

Email Telephone

Relevant experience / Qualifications

September 2003-June 2008	<u>University of Edinburgh</u> M.A Honours Social Anthropology 2.1
September 1996- June 2003	<u>Whickham Comprehensive</u> A level: Business Studies A English Language A Sociology A (AQA)
May 2009-	Integrated Research Methods (module)

A3. Co-applicants (*including student supervisors*)

Co-applicant 1

Title Forename Surname

Post

Department / School / Faculty

Email Telephone

Relevant experience / Qualifications

BSc, Development Studies, Coventry University (2:1)

MPhil, Behavioural Epidemiology, Liverpool John Moores University

I have ten years of experience of conducting original quantitative and qualitative research into the risk behaviour of young people, including in both nightlife environments and international holiday resorts. I have worked at the Centre for Public Health as a researcher since 1999 and currently head a team of ten research staff working on issues including alcohol use, sexual behaviour, recreational drug use and violence.

Co-applicant 2

Title Forename Surname

Post

Department / School / Faculty

Email

Telephone

Relevant experience / Qualifications

- **BSc (Hons) Public Health 2003**
- **MSc Social Research Methods and Statistics 2008**
- **Six years of research experience at the Centre for Public Health, LJMU**
- **Substantial research project management for a wide range of research focusing on violence, injury, alcohol and nightlife**
- **Experience of carrying out surveys in licensed premises, conducting in depth interviews with members of the public (including intimidated witnesses, drug users and young people) and service providers, conducting focus groups, analysing health and crime data and informing local policy and practice in relation to violence and injury prevention and nightlife related issues.**

Co-applicant 3

Title Forename Surname

Post

Department / School /
Faculty

Email Telephone

Relevant experience / Qualifications

Where there are more than 3 co-applicants please append an additional page to your application containing the relevant details

SECTION B – PROJECT DETAILS

B1. Proposed Study Dates

Start Date	25/07/09
End Date	08/09/09

B2. Scientific Justification. State the background and why this is an important area for research (*Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4*)

There is currently a lack of literature about the sexual behaviour of British casual workers in Mediterranean holiday resorts. Previous studies have identified that casual workers in Ibiza show elevated levels of sexual risk taking and a greater number of sexual partners than previously at home in the UK (Hughes, Bellis 2006). In addition, previous investigations have shown that casual workers are more likely to be regular substance users, consuming a high amount of drugs over a longer period of time than holidaymakers (Hughes, Bellis, Chaudry 2004). This contributes to increased levels of unprotected or regretted sex with tourists and other workers, which can result in the spread of sexually transmitted infections (STI) that can then be brought back to the UK.

With this in mind, it is vital that more research is conducted to identify the potential for health initiatives that use casual workers as an essential target for health promotion.

The proposed research will be an evaluation of the sexual health needs and current sexual health services available to British casual workers in Ibiza. This will involve looking at the availability and access to information, contraception and treatment for STDs in the resort from travel companies, local health authorities and British-run organisations. In order to ascertain the needs of the workers, the study will use quantitative and qualitative research methods to investigate levels of sexual activity and risk taking in Ibiza, and factors that may inhibit condom use, such as excessive substance use, in order to examine ways in which better health interventions could be delivered. Furthermore, the study will look at the influence of peer groups and discourse within worker communities on sexual behaviour and attitudes of individuals, and how this may change during their stay. Therefore taking into account the effects of distance from home, duration of stay and daily patterns of socialisation.

Casual workers in Ibiza have daily contact with British tourists and fellow workers, and therefore could potentially be adequate candidates to deliver health messages as peer

educators. The proposed research will provide information about the best possible routes to implement future initiatives providing partnerships between local Spanish health authorities, British-run organisations, casual workers and travel companies.

B3. Give a summary of the purpose, design and methodology of the planned research

(Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4)

The study will use a mixed methods approach using short quantitative questionnaires, semi-structured qualitative interviews and ethnographic observations. This methodology has been chosen to provide a large amount of empirical data in order to produce statistics, as well as more qualitative data to provide a detailed analysis of the individual participant's sexual behaviour and attitudes. Ethnographic observations will be used to provide an insight into the daily behaviour of casual workers and group cultures that may be formed.

Quantitative data will be gathered using a short questionnaire delivered to a sample of casual workers (n=200). Participation will be voluntary and informed consent will be gathered by the researcher. Information will cover topics such as basic demographics, sexual behaviour and levels of substance use whilst in Ibiza. Questionnaires will be distributed at venues frequented by casual workers over a period of two weeks. This will enable the correlation of information about the relationships between substance use, type of casual work, numbers of sexual partners and levels of health information received whilst in Ibiza. Questionnaires will be self-completed and returned to researchers in a sealed envelope to ensure anonymity.

Semi-structured interviews will be used to gain more detailed qualitative data about the behaviours and attitudes of casual workers, and will provide a deeper explanation behind the causes and effects of increased levels of unprotected sex. This method subsequently will help to uncover any contextual influences that may lead to instances of unsafe sex. The proposed interviews would cover key topics such as how workers assess their own sexual health risk whilst in the resort, and how their attitudes may have changed over their stay so far due to peer groups and daily worker discourse.

Ethnographic observations will be used in order to identify the culture of the workers and specific behavioural patterns that may be conducive to becoming a certain type of worker in the resort. This is important in order to understand why certain workers may partake in risk taking behaviour as a means of acceptance into groups.

B4. State the principal research question

The sexual behaviour and sexual health needs of British casual workers in an international nightlife resort

B5a. Give details of the intervention(s) or procedure(s) to be received by participants (including psychological or physical interventions, interviews, observations or questionnaires)

Intervention	Numbers	Avg. Time / Interventions	Is this a novel procedure?
<i>Semi- Structured Interview</i>	<i>30</i>	<i>20 minutes</i>	
<i>Short Quantitative Questionnaire</i>	<i>200</i>	<i>5 minutes</i>	
<i>Ethnographic Observations</i>	<i>30</i>	<i>ongoing</i>	

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

B5b. Where questionnaires are to be used have these previously been validated?

☒ Yes ☐ No

If yes, state by whom and when. If no, you must append copies of the questionnaire to this application.

The questionnaire is based on previously validated questionnaires used in a range of research projects of holidaymakers' risk behaviour abroad. Additional questions have been added to meet the needs of this research project. A copy of the questionnaire is enclosed.

B5c. Where interviews (structured or semi-structured) are proposed you must append an outline of the interview schedule to this application.

B6. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting or is it possible that criminal or other disclosures requiring action could take place during the study? (e.g during interviews or focus groups)

☒ Yes ☐ No

If yes give details of procedures in place to deal with these issues. Information given to participants should make it clear under what circumstances action may be taken

Interviews will include the topics of drug and alcohol consumption, as well as sexual activity. Participants will be fully informed of the nature of the interview. All interviews will be confidential and kept anonymous to further deal with sensitivity or embarrassment.

B7. Where will the intervention take place? (ie LJMU premises, participants' homes, public places etc)

Public bars and areas where British workers socialise in Ibiza.

B8. How will the findings of the research be disseminated?

In addition to the MPhil thesis, the findings will be prepared for peer reviewed publication in a relevant journal.

SECTION C – THE PARTICIPANTS

C1a. Identify the participants for the study (*LJMU staff, LJMU students, members of the public, other please specify*)

British Casual Workers in Ibiza

C1b. How will the participants been selected, approached and recruited? If participants are to be approached by letter/email please append a copy of the letter/email.

The selection criteria for the study is being a British casual worker in Ibiza during summer 2009. Participants will be approached and recruited through:

- 1. The researcher approaching managers of bars, nightclubs, hotels etc. in Ibiza in order to seek permission to attend staff meetings, explain the purpose of the research and recruit participants.*
- 2. The researcher will also visit venues where casual workers socialise and recruit participants individually.*

Compliance will be recorded for both recruitment types.

Participation will be voluntary and participants will be able to withdraw from the study at any time

C2a. What is the total number of participants?

200

C2b. How was this number decided?

Based on previous experience with this type of study, this number was considered to be large enough to provide a meaningful sample in quantitative analyses, yet also achievable within the available data collection period (2 weeks).

C3. Will any of the participants come from any of the following groups. (Please tick all that apply)

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Children under 16 |
| <input type="checkbox"/> | Adults with learning disabilities |
| <input type="checkbox"/> | Adults with mental illness |
| <input checked="" type="checkbox"/> | Drug / Substance users |
| <input type="checkbox"/> | Adults with dementia |
| <input type="checkbox"/> | Young offenders |
| <input type="checkbox"/> | Those with a dependant relationship with the investigator |
| <input type="checkbox"/> | Other vulnerable groups please specify |

Justify their inclusion

The inclusion of drug/substance users is vital to the nature of the question.

C4a. What are the inclusion criteria?

Being British, aged 16-35 and currently undertaking casual work in Ibiza during Summer 2009.

C4b. What are the exclusion criteria?

Those not partaking in casual work, non-British, outside the age limits.

C5. Will any payments/rewards or out of pocket expenses be made to participants?

☐ Yes ☒ No

If yes what or how much?

SECTION D – CONSENT

D1. Will informed consent be obtained from (please tick all that apply)

☒ The research participants?

☐ The research participants, carers or guardians?

☐ Gatekeepers to the research participants?

(ie school authorities, treatment service providers)

D2. Will a signed record of consent be obtained?

☐ Yes ☒ No

To maintain anonymity we will not ask participants for a signed record of consent. However an information sheet will be provided to all participants and informed consent will be gained verbally, with compliance recorded by the researcher.

D3. Will participants, and where applicable, carers, guardians or gatekeepers be provided with an information sheet regarding the nature, purpose, risks and benefits of the study?

☒ Yes ☐ No

If no please explain why not

D4. Will participants be able to withhold consent or withdraw consent to the procedure?

☒ Yes ☐ No

If no please explain why not

SECTION E - RISKS AND BENEFITS (Where risks are identified an LJMU risk assessment form must be completed)

E1. Describe in detail any potential adverse effects, risks or hazards, including any discomfort, distress or inconvenience, of involvement in the study for research participants. *Explain any risk management procedures which will be put in place.*

Potential adverse effect to the participant may come from the disclosure of personal information about sexual activity and substance use. Participants will be guided to necessary agencies in Ibiza and in the UK that can provide them with information to overcome any discomfort.

E2. Explain any potential benefits of the proposed intervention for individual participants.

The researcher will be actively seeking information on health service provision and availability in Ibiza. Individuals involved in the interviews may benefit from knowledge gained through this process.

E3. Describe in detail any potential adverse effects, risks or hazards (mild, moderate, high or severe) of involvement in the research for the researchers. *Explain any risk management procedures which will be put in place.*

There is the potential for aggression or violence from patrons of the resort environment towards researcher.

To overcome this, researcher will be attending premises by permission of manager. Briefing will be made to researcher by trained researchers with previous experience of environment, with regard to approaching people/exit strategy. The researcher will be working in set time period (no later than 11.00pm). All supervisors will be informed via email and telephone of where and when the research will take place to ensure the whereabouts of researcher at all times during the study.

SECTION F – DATA ACCESS AND STORAGE

F1. Will the study involve any of the following activities at any stage (please tick all that apply)

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> | Electronic transfer of data by magnetic or optical media, email or computer networks |
| <input type="checkbox"/> | Sharing of data with other organisations |
| <input type="checkbox"/> | Export of data outside of the European Union |
| <input type="checkbox"/> | Use of personal addresses, postcodes, faxes, emails or telephone numbers |
| <input checked="" type="checkbox"/> | Publication of direct quotations from respondents |
| <input type="checkbox"/> | Publication of data that might allow identification of individuals |
| <input checked="" type="checkbox"/> | Use of audio/visual recording devices |

Storage of personal data on any of the following

- | | |
|-------------------------------------|----------------------------|
| <input type="checkbox"/> | Manual files |
| <input type="checkbox"/> | Home or personal computers |
| <input type="checkbox"/> | Private company computers |
| <input checked="" type="checkbox"/> | Laptop computers |

What measures have been put in place to ensure confidentiality of personal data (eg password protected files, encryption or other anonymisation procedures)?

The personal data will consist of names contact details for individuals recruited to be interviewed. This file will be password protected. Data collected through the interviews will not linked to individuals names in any way.

F2. Who will have control of and act as custodian for the data generated during the procedure?

The The applicant

F3. Who will have access to the data generated?

The applicant and co-applicants

F4. For how long will data for the study be stored?

Until research findings are published (or to a maximum of five years).

***SECTION G NOT APPLICABLE- ONLY FOR HUMAN TISSUE USE**

SECTION H – DECLARATION OF THE PRINCIPAL INVESTIGATOR / SUPERVISOR / STUDENT

The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

I undertake to abide by the ethical principals underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.

If the research is approved I undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.

I undertake to seek an ethical opinion from LJMU REC before implementing substantial amendments to the approved study plan.

If, in the course of the administering any approved intervention, there are any serious adverse events, I understand that I am responsible for immediately stopping the intervention and alerting LJMU REC.

I am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.

I understand that any records/data may be subject to inspection for audit purposes if required in the future.

I understand that personal data about me as a researcher will be held by the University and this will be managed according to the principals of the Data Protection Act.

I understand that the information contained in this application, any supporting documentation and all correspondence with LJMU REC relating to the application will be subject to the provisions of the Freedom of Information Acts. The information may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

I understand that all conditions apply to my co-applicants and other researchers involved in the study and that it is my responsibility that they abide by them.

Signature of Principal Investigator

Date

28/05/09

Print Name

Danielle Kelly

Signature of Supervisor / School Director or nominee

Date

28/05/2009

Print Name

Karen Hughes

SECTION I – CHECKLIST OF ENCLOSURES (Please tick relevant boxes)

<input checked="" type="checkbox"/>	Protocol (MANDATORY)
<input type="checkbox"/>	Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
<input checked="" type="checkbox"/>	Participant Information Sheet
<input type="checkbox"/>	Carer Information Sheet
<input type="checkbox"/>	Gatekeeper Information Sheet
<input type="checkbox"/>	Participant Consent Form
<input type="checkbox"/>	Carer Consent Form
<input type="checkbox"/>	Gatekeeper Consent Form
<input checked="" type="checkbox"/>	Non-validated questionnaires
<input checked="" type="checkbox"/>	Interview schedule
<input checked="" type="checkbox"/>	Risk Assessment Form
<input checked="" type="checkbox"/>	Other please specify
Research proposal	

Please send your completed application form to researchethics@ljmu.ac.uk. A signed paper copy must also be sent to the Research Ethics Administrator, Research Support Office, Liverpool John Moores University, Rodney House, 70 Mount Pleasant, Liverpool L3 5UX

Appendix 3: EU health card information from <https://www.e111.org.uk/about.html>

All About the E111 / EHIC

Below you will find out everything you need to know about the E111 European Health Insurance Card (EHIC).

What is Covered?

The EHIC is normally valid for three to five years and covers any medical treatment that becomes necessary during your trip, because of either illness or an accident. The card gives access to state-provided medical treatment only, and you'll be treated on the same basis as an 'insured' person living in the country you're visiting. Remember, this might not cover all the things you'd expect to get free of charge from the NHS in the UK. You may have to make a contribution to the cost of your care.

The EHIC also covers any treatment you need for a chronic disease or pre-existing illness. You need to make arrangements in advance for kidney dialysis and oxygen therapy. To arrange for kidney dialysis while you're away, contact your NHS renal unit in the UK before you travel. For limited information on oxygen supply services in the EEA countries and Switzerland, call the Department of Health's Customer Service Centre on 020 7210 4850.

Remember that the EHIC won't cover you if getting medical treatment is the main purpose of your trip. You are advised to take out comprehensive private insurance for visits to all countries, regardless of whether you are covered by your EHIC.

Your EHIC should cover you for routine maternity care while you are away. However, if you are going to an EEA country or Switzerland specifically to have your baby, you will need an E112 form.

In Summary, the EHIC will cover:

- Any medical treatment that becomes necessary during your stay because of either illness or an accident.
- The card gives access to reduced-cost or free medical treatment from state healthcare providers.
- It allows you to be treated on the same basis as a resident of the country you are visiting i.e. you may have to pay a patient contribution (also known as a co-payment). You may be able to seek reimbursement for this when you are back in the UK if you are not able to do so in the other country (and limited to the equivalent cost on the NHS).
- It includes treatment of a chronic or pre-existing medical condition that becomes necessary during your visit.
- It includes routine maternity care, (provided the reason for your visit is not specifically to give birth).
- It includes the provision of oxygen, renal dialysis and routine medical care.

It does not cover:

- The EHIC is not a substitute or replacement for private travel insurance. You should always take out an appropriate private policy in addition to carrying your EHIC.
- It will not cover the costs of private healthcare or services that are not part of the state healthcare system.
- It will not cover the costs of being brought back to the UK.

- It will not allow you to go abroad to specifically receive treatment (including going abroad to give birth).
- The card may not be used in some regions, as there may be no state provided healthcare available.

Who Is Eligible?

If you are a UK resident, you are entitled to medical treatment that becomes necessary, at reduced cost or sometimes free, when temporarily visiting a European Union (EU) country, Iceland, Liechtenstein, Norway or Switzerland. Only treatment provided under the state scheme is covered.

However, to obtain treatment you will need to take a European Health Insurance Card (EHIC) with you. Please note: Not all UK residents are covered in Denmark, Iceland, Liechtenstein, Norway or Switzerland. Click on the 'Health Advice for Travellers' link below, if you are unsure whether you are covered.

People who are ordinarily resident in the UK are entitled to a UK-issued EHIC. It is not valid for people who are going to live abroad. There are some restrictions, depending on your nationality:

- UK and other EU nationals, stateless persons and refugees are covered in all EEA countries and Switzerland. However, if you are a national of Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia, your EHIC is not valid in Switzerland.
- Nationals of Iceland, Liechtenstein and Norway are covered in all EEA countries but not in Switzerland.
- People who do not have UK, EU, EEA or Swiss nationality are covered in all EU countries but not in Denmark, Norway, Liechtenstein or Switzerland. In Iceland, these people are covered for emergency treatment only.
- Swiss nationals are covered in all EU countries but not in Liechtenstein or Norway. In Iceland they are covered for emergency treatment only.
- Dependants of EEA nationals who are ordinarily resident in the UK are covered in all EEA countries and Switzerland, irrespective of their own nationality.

What Are the Requirements?

You can apply for an EHIC for your spouse/partner and any children up to the age of 16 (or 19 if they are in full-time education) at the same time as applying for your own. If you are a foster parent or guardian (including boarding school teaching staff), you can apply on behalf of any children you are looking after.

You must be over 16 to apply as a main applicant. Before you apply, you will need to have the following information to hand for everyone you are applying for:

- Name and Date of Birth
- NHS or National Insurance (NI) Number.

In Scotland the NHS number is known as the Community Health Index (CHI) number and in Northern Ireland it is known as the Health and Care number).

The EHIC is issued by the Prescription Pricing Authority (PPA) and is free of charge.

Appendix 4: Newspaper reports of casual workers drug dealing activities

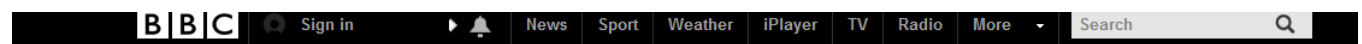
visit to our site and to bring you advertisements that might interest you. Read our [Privacy](#) and [Cookie](#) policies to find out more.

Lifestyle > London Life

Drink, cheap coke, back-to-back parties - and drug stooges: this is the Ibiza world

As two British girls sit in a Peruvian prison for alleged cocaine smuggling, Ibiza is still partying hard. Maxine Frith reports on the drug-running gangs threatening the island's social scene

MAXINE FRITH | Thursday 15 August 2013 | [0 comments](#)



newsbeat

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British workers say raids 'won't stop' Ibiza drug trade

By Simon Mundie
Newsbeat reporter in Ibiza

1 Sep 2010



Spain
The Observer

Tess Reidy in San Antonio,
Ibiza

Saturday 17 August 2013 22:00 BST



This article is 2 years old

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Ibiza: 'Nothing is innocent and dealing is normal'

As two women who worked on the island face drug-smuggling charges in Peru, other Britons who work there warn of how easy it is to be drawn into the culture of crime



Pacha has all the fabled nightclub glamour of Ibiza, but the holiday island has an increasingly darker side.
Photograph: Steve Black/Rex

Lovers jailed for £1million drugs deal after meeting dealer in Ibiza

A COUPLE have been jailed for taking part in a £1million drugs racket after befriending a dealer while on holiday in Ibiza.

By JOHN CHAPMAN

PUBLISHED: 00:01, Tue, Feb 3, 2015 | UPDATED: 15:38, Fri, Mar 20, 2015

SHARE  TWEET    



The jailed couple Leah Parkes and Charles Hendrie

Leah Parkes, 28, and her boyfriend Charles Hendrie, 30, met Abib Asfour, 26, during a romantic break in July 2013.

They began dealing recreational drugs to clubbers while also selling tickets to events on the

Mos

1

2

3


4

5

Appendix 5: Examples of current health literature for young travellers

Thomas Cook (holiday company)- <http://www.thomascook.com/blog/holidays/top-tips-when-drinking-alcohol-abroad/>


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 **Thomas Cook**


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[Categories:](#) [Ask the Experts](#) [Hotel of the Week](#) [Holiday Tips and Advice](#) [Thomas Cook's To](#)



Top Tips When Drinking Alcohol Abroad

by  [Lewis Spratt](#) Posted: 7th September 2013

Drinkaware is an independent, UK-wide charity that aims to increase awareness and understanding of the role of alcohol in society, so people can make informed choices about their drinking.

Holidays come in all shapes and forms. Some are all about relaxation, and some are more about letting your hair down! Whether you're going on holiday alone, with friends or as a family, make the most of your summer holiday with our top tips on enjoying [alcohol](#) responsibly.

Ask the Experts - Drinkaware - Logo **It's Water to the Rescue**

A combination of alcohol and sweating can leave you severely dehydrated which can put a real dampener on your holiday activities. Simply carrying a bottle of water with you and taking regular sips ensures that you stay hydrated and on top of your game.

Gap Year Website- <https://www.gapyear.com/articles/148732/drugs-abroad>

 **journeys are made**
@gapyear.com

Book your gap year - call us:
0333 333 9923

Login » Sign

Plan Your Trip Book Your Trip Volunteering Jobs Countries **Articles** Blogs & Photos Boards

Search the site

Type Country Search

Related Topics

Articles

- ▶ Travel Essentials
- ▶ Travel Health
- ▶ Travel Safety

UK Government Travel Website- www.fco.gov.uk/travel





WHAT YOU NEED TO KNOW ABOUT HIV ABROAD

A guide for people travelling abroad on holiday, on business or to visit friends and family



As you travel to areas abroad it is important to be aware of the different standards of condom use and the different standards of sexual health services. This is a guide to help you understand the different standards and what you need to know about them.

What is sex?

Sex is the act of sexual intercourse. It is the act of sexual intercourse between two people. It is the act of sexual intercourse between two people.

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Appendix 6: Longitudinal holidaymakers study survey 1

Sexual Health 2011 (1)

Thank you for taking part in our study. You are participating in this survey as you have told us that you are going on holiday or travelling abroad in the near future. This questionnaire asks about your sexual behaviour, substance use and nightlife experiences in the last 12 months. The questionnaire should take 5-10 minutes to complete.

1. How old are you?

2. What is your sex? ☐ Male ☐ Female

3. What is your country of residence?

4. Where are you going on your holiday/travels?

5. How long are you staying?

Months Weeks Days

6. Are you:
 Going for a holiday ☐
 Going to work ☐
 (please specify type of work)

7. How many people are you travelling with?

Males Females

8. Are they (please tick all that apply):
 Friends ☐
 Family ☐
 Sexual partner/Spouse ☐
 Work colleagues ☐
 Other ☐

9. Why did you choose this destination? (please tick all that apply)

Weather ☐ Drugs ☐
 Nightlife ☐ Culture ☐
 Family/ Friends ☐ Music ☐
 Opportunities for sex ☐ Cost ☐
 Other (please specify)

10. Have you been to this destination before? Yes ☐ No ☐
 If yes, how many times?

11. On average, in the UK, how frequently do you visit a bar or a nightclub:

	Never	Less than once a month	1-3 times a month	Once a week	2-4 days a week	5 or more days a week
Bar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightclub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. In the last 12 months in the UK, how often have you used the substances listed below: (please tick the appropriate boxes)

	Never used	Have used but not in the last 12 months	Less than once a month	1-3 times a month	Once a week	2-4 days a week	5 or more days a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>						

How often do you get drunk? ☐ ☐ ☐ ☐ ☐ ☐ ☐

13. In the past 12 months have you tried or started using any drugs that you had not previously used?

Yes ☐ No ☐

If yes, what?

14. How many people have you had in the past 12 months?

Males	<input type="text"/>	Females	<input type="text"/>
-------	----------------------	---------	----------------------

15. With how many of people did you always use a condom?

Males	<input type="text"/>	Females	<input type="text"/>
-------	----------------------	---------	----------------------

16. If you had sex without a condom in the past 12 months, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Have you had sex in the past 12 months that you have later regretted?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

18. If yes, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following sets of questions are about your health in the past 3 months.

19. In the past 3 months how many times have you:

Injured yourself after drinking alcohol	<input type="text"/>
Felt ill/hung-over after drinking alcohol	<input type="text"/>
Got into a fight after drinking alcohol	<input type="text"/>
Missed or been late for work/ a lecture/appointment after drinking alcohol	<input type="text"/>
Thought you were pregnant or had got someone pregnant after drinking alcohol	<input type="text"/>

20. In the past 3 months, how many times have you:

Injured yourself after using drugs	<input type="text"/>
Felt ill/ hung-over after using drugs	<input type="text"/>
Got into a fight after using drugs	<input type="text"/>
Missed or been late for work/a lecture/ appointment after using drugs	<input type="text"/>
Thought you were pregnant or had got someone pregnant after using drugs	<input type="text"/>

22. In the past 3 months have you received any of the following (tick all that apply):

Sexual health check up	<input type="checkbox"/>
Emergency contraception	<input type="checkbox"/>
Pregnancy testing	<input type="checkbox"/>
Advice or information about alcohol	<input type="checkbox"/>
Advice or information about drugs	<input type="checkbox"/>
Advice or information about sex	<input type="checkbox"/>

Thank you

For further information about this survey please contact D.Kelly@ljam.ac.uk



Appendix 7: Longitudinal holidaymakers study survey 2

Sexual Health 2011 (2)

Thank you for taking part in our study. You are participating in this survey as you have told us that you have recently been on holiday and have already taken part in our first survey. This questionnaire asks about your sexual behaviour, substance use and nightlife experiences on your holiday. The questionnaire should take 5-10 minutes to complete.

1. How old are you?

2. What is your sex? ☐ Male ☐ Female

3. Where did you go on your holiday/travels?

4. How long did you stay?

Months Weeks Days

5. How many nights per week did you visit:

a bar

a nightclub

6. Whilst abroad, how often did you use the substances listed below:
(please tick the appropriate boxes)

	Never	Less than once a week	Once a week	2-4 days a week	5 or more days a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Whilst abroad, have you tried or started using any drugs that you had not previously used?

Yes ☐ No ☐

If yes, what?

8. How many days per week whilst abroad would you say you were drunk?

9. How many people did you have sex with whilst abroad?

Males Females

10. With how many of these people did you always use a condom?

Males Females

11. If you had unprotected sex whilst abroad, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Did you have sex whilst abroad that you later regretted?

Yes ☐ No ☐

13. If yes, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How many times during your holiday did you receive health treatment or advice?

15. How many times during your holiday have you:

Injured yourself after drinking alcohol

Felt ill/hung-over after drinking alcohol

Got into a fight after using alcohol

Thought you were pregnant or had got someone pregnant after using alcohol

16. How many times during your holiday have you:

- | | |
|---|----------------------|
| Injured yourself after using drugs | <input type="text"/> |
| Felt ill/ hung-over after using drugs | <input type="text"/> |
| Got into a fight after using drugs | <input type="text"/> |
| Thought you were pregnant or had got someone pregnant after using drugs | <input type="text"/> |

17. Whilst abroad did you receive any of the following:

- | | |
|-------------------------------------|--------------------------|
| Sexual health check up | <input type="checkbox"/> |
| Emergency contraception | <input type="checkbox"/> |
| Pregnancy testing | <input type="checkbox"/> |
| Advice or information about alcohol | <input type="checkbox"/> |
| Advice or information about drugs | <input type="checkbox"/> |
| Advice or information about sex | <input type="checkbox"/> |

Thank you

For more information about this survey
please contact D.Kelly@ljmu.ac.uk



Appendix 8: Longitudinal holidaymakers study survey 3

Sexual Health 2011 (3)

Thank you for taking part in our study. You are participating in this survey as you have already taken part in the first two surveys. This questionnaire asks about your sexual behaviour, substance use and nightlife experiences in the past 3 months since returning from your holiday. The questionnaire should take about 5-10 minutes to complete.

1. How old are you? 2. What is your sex? ☐ Male ☐ Female

3. Where did you go on your holiday/travels?

4. Since returning from your holiday, how often have you frequented a bar or nightclub:

	Never	Less than once a month	1-3 times a month	Once a week	2-4 days a week	5 or more days a week
Bar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightclub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Since you have returned from your holiday, how often have you used the substances listed below:
(please tick the appropriate boxes)

	Never used	Have used but not in the past 3 months	Less than once a month	1-3 times a month	Once a week	2-4 times a week	5 or more times a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often do you get drunk? ☐ ☐ ☐ ☐ ☐ ☐ ☐

6. Since returning from your holiday, have you tried or started using any drugs that you had not previously used?

Yes ☐ No ☐

If yes, what?

7. How many people have you have sex with in the past 3 months?

Males Females

8. With how many of these people did you always use a condom?

Males Females

9. If you had unprotected sex in the past 3 months, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have you had sex in the past 3 months that you later regretted?

Yes ☐ No ☐

11. If yes, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Since returning from your holiday, how many times have you received health treatment or advice?

13. How many times in the past 3 months have you:

- | | |
|--|----------------------|
| Injured yourself after drinking alcohol | <input type="text"/> |
| Felt ill/ hung-over after drinking alcohol | <input type="text"/> |
| Got into a fight after drinking alcohol | <input type="text"/> |
| Missed or been late for work/ a lecture/appointment after drinking alcohol | <input type="text"/> |
| Thought you were pregnant or had got someone pregnant after drinking alcohol | <input type="text"/> |

14. How many times in the past 3 months have you:

- | | |
|---|----------------------|
| Injured yourself after using drugs | <input type="text"/> |
| Felt ill/ hung-over after using drugs | <input type="text"/> |
| Got into a fight after using drugs | <input type="text"/> |
| Missed or been late for work/ a lecture/ appointment after using drugs | <input type="text"/> |
| Thought you were pregnant or had got someone pregnant after using drugs | <input type="text"/> |

15. In the past 3 months have you received any of the following:

- | | |
|-------------------------------------|----------------------|
| Sexual health check up | <input type="text"/> |
| Emergency contraception | <input type="text"/> |
| Pregnancy testing | <input type="text"/> |
| Advice or information about alcohol | <input type="text"/> |
| Advice or information about sex | <input type="text"/> |
| Advice or information about drugs | <input type="text"/> |

Thank you

For more information about this survey
please contact D.Kelly@ljamu.ac.uk



Appendix 9: Ethics form for Longitudinal holidaymakers study



Research Ethics Committee Application

Application for Ethical Approval of Undergraduate, Postgraduate or Staff Research involving Human Participants or the Use of Personal Data

Where research involving human participants or databases of personal information is being conducted by a member of staff or student LJMU Research Ethics Committee (REC) considers and advises researchers on the ethical implications of their study.

No research must be started without full, unconditional ethical approval.

Applications must be made using this form and must be typed. Please note that the only valid version of this application form is the current version found online. Previous versions will not be accepted.

Guidance on completing this form can be found at

<http://www.ljmu.ac.uk/RGSO/93717.htm>

Applications, inclusive of specified attachments, can be emailed to LJMU REC via researchethics@ljmu.ac.uk. A paper copy of the signature page only must also be sent to the Research Ethics Administrator, Research Support Office, Rodney House. Applications must be received by the submission dates published on the RSO website.

Where a University research project is to be undertaken using NHS patients, staff or resources or

the work must undergo ethical review via the National Research Ethics Service (NRES). University staff or students undertaking such research need not complete this form but must submit a completed [LJMU Research Governance Proforma](#) and provide LJMU REC with written evidence of full, unconditional ethical approval from NRES prior to commencing their research. On receiving confirmation of NRES ethical approval formal notification of LJMU REC approval will be issued via Chair's action.

Where teaching practices involve invasive (psychological or physiological) procedures on human participants staff should refer to the guidance provided at <http://www.ljmu.ac.uk/RGSO/93087.htm> regarding the development of departmental/faculty codes of practice. Codes of Practice will receive blanket approval for a period of 5 years from LJMU REC.

Potential participants must not be contacted until written approval has been received from the LJMU REC.

Application for Ethical Approval of Research Involving Human Participants

Research Mode

<input type="checkbox"/>	Undergraduate – specify course	
<input type="checkbox"/>	Postgraduate	
<input type="checkbox"/>	MRes,	
<input type="checkbox"/>	MPhil,	
<input checked="" type="checkbox"/>	PhD	
<input type="checkbox"/>	Prof Doc	
<input type="checkbox"/>	Other – please specify	

<input type="checkbox"/>	Postdoctoral
<input type="checkbox"/>	Staff project
<input type="checkbox"/>	Other – please specify

Has this application previously been submitted to the University REC for review? – No

If yes please state the original REC and,

Ref Number

the date of the REC meeting at which it was last

reviewed

Section A – The Applicant

A1a. Title of the Research

The changes in sexual behaviour and substance use of tourists returning from an international nightlife resort

A2. Principal Investigator (PI) (*Note that the in the case of postgraduate or undergraduate research the student is designated the PI. For research undertaken by staff inclusive of postdoctoral researchers and research assistants the staff member conducting the research is designated the PI.*)

Title Forename Surname

Post

Department / School / Faculty

Email Telephone

Relevant experience / Qualifications

September 2003-June 2008	<u>University of Edinburgh</u> M.A Honours Social Anthropology 2.1
September 1996- June 2003	<u>Whickham Comprehensive</u> A level: Business Studies A English Language A Sociology A (AQA)
May 2009- Integrated Research Methods (module)	
June 2009- An introduction to SPSS (module)	
Completion of Viva examination for transfer from MPhil- PhD March 2011	

A3. Co-applicants (*including student supervisors*)

Co-applicant 1

Title **Professor** Forename **Mark** Surname **Bellis**

Post **Director**

Department / School / Faculty **Faculty of Health and Applied Social Sciences**

Email **M.A.Bellis@ljmu.ac.uk** Telephone **0151 231 4511**

Relevant experience / Qualifications

Director of the Centre for Public Health, LJMU, the North West Public Health Observatory and the World Health Organization Collaborating Centre for Violence Prevention. Heads a team of academics and health professionals on national and international projects addressing alcohol and drug use, sexual behaviour, violence, and public health intelligence. He has been an expert advisor on drug prevention to both the United Nations (UNODC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Mark is currently the lead academic for the UK Drugs Focal Point and IREFREA - a European Union collaborative examining substance use (alcohol and drugs), sexual risk taking and prevention in young people across Europe. Professor Bellis is a founding member of Club Health (www.clubhealth.org.uk), an international initiative sharing good practice on nightlife health.

Co-applicant 2

Title **Miss** Forename **Karen** Surname **Hughes**

Post **Reader, Behavioural Epidemiology**

Department / School /
Faculty

Faculty of Health and Applied Social Sciences

Email **K.E.Hughes@ljmu.ac.uk**

Telephone **0151 231 4453**

Relevant experience / Qualifications

BSc, Development Studies, Coventry University (2:1)

MPhil, Behavioural Epidemiology, Liverpool John Moores University

I have twelve years of experience of conducting original quantitative and qualitative research into the risk behaviour of young people, including in both nightlife environments and international holiday resorts. I have worked at the Centre for Public Health as a researcher since 1999 and I am currently working on issues including alcohol use, sexual behaviour, recreational drug use and violence.

Co-applicant 3

Title **Dr** Forename **Diana** Surname **Leighton**

Post **Research Excellence Framework Manager**

Department / School /
Faculty

**Research Support Office (Office of Academic Enhancement,
Research and Regional Engagement)**

Email **d.j.leighton@ljmu.ac.uk**

Telephone **0151 904 6472**

Relevant experience / Qualifications

BSc (Hons, Sports Science); PhD (Epidemiology of Back Pain); postdoctoral research experience in health/occupational health; MBA. Currently enrolled on LJMU's Doctorate in Business Administration programme.

Where there are more than 3 co-applicants please append an additional page to your application containing the relevant details

SECTION B – PROJECT DETAILS

B1. Proposed Study Dates

Start Date	30/07/11
End Date	30/11/11

B2. Scientific Justification. State the background and why this is an important area for research (*Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4*)

Previous research has shown elevated sexual behaviour and substance use amongst young people in holiday resorts (e.g. Bellis et al 2007; Tutenges and Hesse 2008; Sonmez et al 2006). However, whilst tourists and casual workers may take part in new hedonistic activities in holiday destinations, such as excessive drinking and drug taking, very little is currently known about whether and how this behaviour continues on their return to the UK.

Youth package holiday companies, peers and locals may expose tourists to behaviour outside of their normal social boundaries. Consequently, there is a potential for young people to experience a change in attitude towards sexual behaviour and substance use whilst abroad as risk behaviours become normalised, particularly in environments where risky behaviour is often encouraged and permissible.

When returning to the UK, young people may try to re-enact their experiences, particularly when it comes to substance use and sexual behaviour. Nightlife events in the UK are increasingly being organised to cater for the youth tourist market, such as holiday reunion events and foam parties. Therefore this may attract young people to nightlife venues on return to the UK to relive the experiences found in the holiday resort.

It is important to measure the attitudes and behavioural changes that tourists may

experience before, during and after their time abroad; and their potential to maintain new risk behaviours on return to the UK, as a result of their experience. The consequences of such risk behaviours can lead to increased substance use, the spread of sexually transmitted diseases and unwanted pregnancies, as well as other long term health risks. Furthermore, it is vital to understand the burden that young holidaymakers may have on UK health services in order to understand the potential for future health initiatives.

B3. Give a summary of the purpose, design and methodology of the planned research

(Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4)

Objectives:

- To measure changes in attitude and behaviour regarding sexual behaviour and substance use experienced by young people after visiting international holiday resorts.
- To understand the reasons and influences behind attitude and behavioural changes as a consequence of visiting a international holiday resorts.
- To understand the use of sexual health and substance use services in the UK to identify health burdens and the needs of young holidaymakers.

Methodology

This would include a longitudinal study of a group of British tourists visiting youth related holiday resorts, over three periods; before, straight after and 3 months after their holiday.

In each period the study would look at:

- Levels of substance use and intoxication
- Number of sexual partners
- Instances of risky or unprotected sex
- Attendance at nightlife events
- Influences on behaviour
- Healthcare services and information received

Method

An online quantitative questionnaire will be used similar to those previously used in studies of tourists and casual workers (Bellis et al 2004; 2007; Hughes et al 2004; 2006). Participants will be identified using individual codes, which will also be used to access the online questionnaire.

The first stage will involve emailing a unique code to participants to access the online questionnaire before they are about to go abroad; looking at the behaviour of individuals in the previous three months before their holiday. Using their unique code, participants will then be asked to do a follow up questionnaire straight after their holiday; and then three months after their return to the UK looking at their behaviour in the time after their holiday.

The final stage will involve the use of focus groups to ascertain a more in depth description of behaviour of those returning from their holiday. This will take place during the three month period after the time spent abroad. Focus group discussions will be recorded using a Dictaphone.

Recruitment of sample

Young British tourists, aged 16-35, would be recruited using two strategies: through social networking sites such as Facebook and Twitter; and using online tourist forums. The target size of the sample to fill in all three questionnaires will be 60 individuals; therefore 100 individuals will be originally approached.

Participants for focus groups will be recruited from those taking part in the short questionnaires.

B4. State the principal research question

The changes in sexual behaviour and substance use of tourists returning from an international nightlife resort

B5a. Give details of the intervention(s) or procedure(s) to be received by participants (including psychological or physical interventions, interviews, observations or questionnaires)

Intervention	Numbers per individual participant	Avg. Time / Intervention / participant	Is this a novel procedure?
<i>Questionnaire 1</i>	<i>100</i>	<i>10minutes</i>	<i>no</i>

<i>Questionnaire 2</i>	<i>100</i>	<i>10minutes</i>	<i>no</i>
<i>Questionnaire 3</i>	<i>100</i>	<i>10minutes</i>	<i>no</i>
<i>Focus group</i>	<i>30</i>	<i>30 minutes</i>	<i>no</i>

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

B5b. Where questionnaires are to be used have these previously been validated?

☒ Yes ☐ No ☐ Not Applicable

If yes, state by whom and when. If no, you must append copies of the questionnaire to this application.

The questionnaires are based on previously validated questionnaires used in a range of research projects of holidaymakers' risk behaviour abroad. Additional questions have been added to meet the needs of this research project. Copies of the questionnaires are enclosed.

B5c. Where interviews (structured or semi-structured) are proposed you must append an outline of the interview schedule to this application.

B6. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting or is it possible that criminal or other disclosures requiring action could take place during the study? (e.g during interviews or focus groups)

☒ Yes ☐ No ☐ Not Applicable

If yes give details of procedures in place to deal with these issues. Information given to participants should make it clear under what circumstances action may be taken

Questionnaires and focus groups will include the topics of drug and alcohol consumption, as well as sexual activity. Participants will be fully informed of the nature of the questionnaire and the focus group. All questionnaires and focus groups will be confidential and kept anonymous to further deal with sensitivity or embarrassment.

Information about support services will be available to participants; this will include sexual health services, substance abuse support services and sexual and domestic violence support services.

B7. Where will the intervention take place? (ie LJMU premises, participants' homes, public places etc)

There will be a link to the online questionnaire so the researcher will be based in the Centre for Public Health, LJMU.

Focus groups will take place at the Centre for Public Health, LJMU

B8. How will the findings of the research be disseminated?

In addition to the PhD thesis, the findings will be prepared for peer reviewed publication in a relevant journal.

SECTION C – THE PARTICIPANTS

C1a. Identify the participants for the study (LJMU staff, LJMU students, members of the public, other please specify)

British holidaymakers

C1b. How will the participants been selected, approached and recruited? If participants are to be approached by letter/email please append a copy of the letter/email.

The selection criteria for the study is being British, aged 16-35 and travelling to a holiday destination during August/September 2011. Participants will be approached and recruited through:

1. The social networking sites Facebook and Twitter. Participants will be approached to join a

group that will outline the nature of the research, and will invite them to take part in the study.

2. Online holiday forums. Participants will be approached by posting a notice of the research and inviting people to take part.

C2a. What is the total number of participants?

100

C2b. How was this number decided?

Researchers within the Centre for Public Health, LJMU, were consulted for advice about the potential number of participants that may take part in a paired analysis study. The number was considered to be an appropriate amount to provide a meaningful quantitative analysis, yet also achievable within the data collection period.

C3a. Will any of the participants come from any of the following groups? (Please tick all that apply)

Please note that the Mental Capacity Act 2005 requires that all research involving participation of any adult who lacks the capacity to consent through learning difficulties, brain injury or mental health problems be reviewed by an ethics committee operating under the National Research Ethics Service (NRES). For further information please see <http://www.ljmu.ac.uk/RGSO/101579.htm>

<input type="checkbox"/>	Children under 16
<input type="checkbox"/>	Adults with learning disabilities
<input type="checkbox"/>	Adults with mental illness (if yes please specify type of illness below)
<div></div>	
<input checked="" type="checkbox"/>	Drug / Substance users
<input type="checkbox"/>	Young offenders
<input type="checkbox"/>	Those with a dependant relationship with the investigator
<input type="checkbox"/>	Other vulnerable groups please specify

Justify their inclusion

The inclusion of drug/substance users is vital to the nature of the question.

C3b. If you are proposing to undertake a research study involving interaction with children do you have current, valid clearance from the Criminal Records Bureau (CRB)

Not applicable

C4a. What are the inclusion criteria?

Being British aged 16-35 and planning to travel to a holiday destination in August/September 2011.

C4b. What are the exclusion criteria?

Not being British and being outside of the age limits.

C5. Will any payments/rewards or out of pocket expenses be made to participants?

☐ **Yes** ☒ **No**

If yes what or how much?

SECTION D – CONSENT

D1. Will informed consent be obtained from (please tick all that apply)

- | | |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | The research participants? |
| <input type="checkbox"/> | The research participants, carers or guardians? |
| <input type="checkbox"/> | Gatekeepers to the research participants?
(ie school authorities, treatment service providers) |

D2. Will a signed record of consent be obtained? Please note that where the study involves the administration of a questionnaire or survey a signed record of consent is not required for completion of the questionnaire as long as it is made clear in the information sheet that completion of the questionnaire is voluntary. Under these circumstances return of the completed questionnaire is taken as implied consent.

In such cases the REC would expect a statement to be included at the start of the questionnaire where the respondent confirms that they have read the participant information sheet and are happy to complete the questionnaire.

Participation in any other interventions within the same study eg interviews, focus groups must be supported by obtaining appropriate written consent.

<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
-------------------------------------	-----	--------------------------	----

The participants of the questionnaire will not sign a record of consent. However an information sheet will be provided to all participants and informed consent will be gained using a tick box on the online questionnaire, with compliance recorded by the researcher.

Participants of the focus groups will be asked to sign a consent form.

D3. Will participants, and where applicable, carers, guardians or gatekeepers be provided with an information sheet regarding the nature, purpose, risks and benefits of the study?

<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
-------------------------------------	-----	--------------------------	----

If no please explain why not

D4. Will participants be able to withhold consent or withdraw consent to the procedure?

☒ Yes ☐ No

If no please explain why not

SECTION E - RISKS AND BENEFITS (Where risks are identified an LJMU risk assessment form must be completed)

E1. Describe in detail any potential adverse effects, risks or hazards, including any discomfort, distress or inconvenience, of involvement in the study for research participants. *Explain any risk management procedures which will be put in place.*

Potential adverse effect to the participant may come from the disclosure of personal information about sexual activity and substance use. Participants will be guided to necessary agencies in the UK that can provide them with information to overcome any discomfort.

E2. Explain any potential benefits of the proposed intervention for individual participants.

The researcher will be actively seeking information on health service provision and availability in holiday destinations and in the UK. Individuals involved in the focus groups may benefit from knowledge gained through this process.

E3. Describe in detail any potential adverse effects, risks or hazards (mild, moderate, high or severe) of involvement in the research for the researchers. *Explain any risk management procedures which will be put in place.*

There is the potential for researcher to communicate with fraudulent or dangerous participants on social networking sites and internet forums. However this risk is mild and will be minimised by using established networks to initiate the recruitment process.

Focus group participants will be recruited from the same established network. Focus groups will take part at the Centre for Public Health, LJMU. The researcher will be working in set time period (no later than 7.00pm) and will be accompanied by a senior researcher at all times.

SECTION F – DATA ACCESS AND STORAGE

F1. Will the study involve any of the following activities at any stage (please tick all that apply)

Applicants should note that no personal identifiable information or sensitive information relating to participants should be transferred in or out of the EU without the consent of participants. Similarly where the use of verbatim quotes is proposed in future publications or presentations or it is intended that information is gathered using audio/visual recording devices explicit consent for this must be sought from participants.

<input type="checkbox"/>	Electronic transfer of data by magnetic or optical media, email or computer networks
<input type="checkbox"/>	Sharing of data with other organisations
<input type="checkbox"/>	Export of data outside of the European Union
<input checked="" type="checkbox"/>	Use of personal addresses, postcodes, faxes, emails or telephone numbers
<input checked="" type="checkbox"/>	Publication of direct quotations from respondents
<input type="checkbox"/>	Publication of data that might allow identification of individuals
<input checked="" type="checkbox"/>	Use of audio/visual recording devices

Storage of personal data on any of the following:

<input type="checkbox"/>	Manual files
<input type="checkbox"/>	Home or personal computers
<input type="checkbox"/>	Private company computers
<input checked="" type="checkbox"/>	Laptop computers

Applicants should note that only in exceptional circumstances will the storage of personal identifiable or sensitive information relating to participants on home or laptop computers or private company computers.

What measures have been put in place to ensure confidentiality of personal data (eg password protected files, encryption or other anonymisation procedures)? If you have checked any of the boxes above please provide justification for such activity.

Only the email addresses of participants will be recorded in order to send out the codes for the online questionnaires and focus groups. The data will be collected on the online questionnaire system which will be password protected. Email addresses will be stored in a password encrypted file.

Recordings from the focus groups will be immediately transcribed onto a password protected computer on LJMU premises, recordings will then be permanently removed from the Dictaphone. Focus group participants will only be identified by the same unique code issued to them from the online questionnaire.

F2. Who will have control of and act as custodian for the data generated during the procedure?

The applicant

F3. Who will have access to the data generated?

The applicant and co-applicants

F4. For how long will data for the study be stored?

Until research findings are published (or to a maximum of five years).

Once you have completed the above application form please submit it electronically to researchethics@ljmu.ac.uk. If possible please submit your application form and any additional supporting documentation as a single pdf file.

Both you and you supervisor or school director must sign the signature page below, complete the checklist of documents sent electronically and send a paper copy of the following 2 pages only to the Research Ethics Administrator, Research Support Office, Rodney House, 70 Mount Pleasant, Liverpool L3 5UX.

Please ensure that you complete the summary project details below to ensure that your signature page can be associated with your electronic submission for approval.

Title of the Research Study

The changes in sexual behaviour and substance use of tourists returning from an international nightlife resort

Principal Investigator (PI)

Title Forename Surname

For RSO use only

Date received	Initials	LJMU REC Ref

DECLARATION OF THE PRINCIPAL INVESTIGATOR / SUPERVISOR / STUDENT

The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

I undertake to abide by the ethical principles underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.

If the research is approved I undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.

I undertake to seek an ethical opinion from LJMU REC before implementing substantial amendments to the approved study plan.

If, in the course of the administering any approved intervention, there are any serious adverse events, I understand that I am responsible for immediately stopping the intervention and alerting LJMU REC.

I am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.

I understand that any records/data may be subject to inspection for audit purposes if required in the future.

I understand that personal data about me as a researcher will be held by the University and this will be managed according to the principals of the Data Protection Act.

I understand that the information contained in this application, any supporting documentation and all correspondence with LJMU REC relating to the application will be subject to the provisions of the Freedom of Information Act. The information may be disclosed in response to requests made under the Act except where statutory exemptions apply.

I understand that all conditions apply to my co-applicants and other researchers involved in the study and that it is my responsibility that they abide by them.

Signature of Principal Investigator

Date

Print Name

Danielle Kelly

Signature of Supervisor / School Director or nominee

Date

Print Name

Karen Hughes

CHECKLIST OF DOCUMENTS SUBMITTED ELECTRONICALLY (Please tick relevant boxes)

<input checked="" type="checkbox"/>	Ethics Application Form (MANDATORY)
<input checked="" type="checkbox"/>	Protocol (MANDATORY) see note below
<input checked="" type="checkbox"/>	Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
<input checked="" type="checkbox"/>	Participant Information Sheet
<input type="checkbox"/>	Carer Information Sheet
<input type="checkbox"/>	Gatekeeper Information Sheet
<input checked="" type="checkbox"/>	Participant Consent Form
<input type="checkbox"/>	Carer Consent Form
<input type="checkbox"/>	Gatekeeper Consent Form
<input checked="" type="checkbox"/>	Non-validated questionnaires
<input checked="" type="checkbox"/>	Interview schedule
<input checked="" type="checkbox"/>	Risk Assessment Form
<input type="checkbox"/>	Other please specify

Note

A research protocol is a document describing in detail how a research study is to be conducted in practice, including a brief introduction or background to the study, the proposed methodology and a plan for analysing the results. For the purposes of your application for ethical approval it is something which can be presented in a variety of formats dependent on its origin for example:

- *for postgraduate research students it may be the programme of work embedded within their programme registration form (RD9R)*
- *for studies which have obtained external funding it is often the description of what they propose doing which they submitted to the funder*
- *for other students it is the study proposal they have written and had assessed/approved by their supervisor.*

Going on holiday this summer?



I'm looking for volunteers to take part in my PhD study on holidaymakers

Please turn over to find out more!

I am a PhD student at **Liverpool John Moores University** looking for participants to take part in a short study.

If you are aged between 16-35 and are planning to go on holiday or work abroad this summer I would like you to take part! If you are not going on holiday, but know someone who is, please pass this on!

The link at the bottom of the page takes you to a short online questionnaire that will take only **5 minutes** to complete. The questionnaire is completely anonymous and you do not have to disclose any personal information.

A follow up questionnaire will be sent to you just after your holiday and then again 3 months after your return so we will require your **email address** only. No names or any other form of identification needed! Simple!

The purpose of the study is to identify the sexual behaviour and substance use of British holidaymakers before, during and after their time spent abroad in order to understand their health needs. The research will be used to evaluate the current sexual health and substance use services available in the UK and abroad, and to identify the potential for the expansion of future health provision for tourists and casual workers.

Here's the link:

<http://www.surveymonkey.com/s/holidayhealth>

Or email me and I will send it to you

Thanks for your time!

Danielle Kelly

D.Kelly@ljmu.ac.uk

Appendix 11: NHS walk in service information from

<http://www.liverpoolcommunityhealth.nhs.uk/health-services/walk-in-centres/liverpool-city-centre-nhs-walk-in-centre.htm>

[HOME](#) [OUR PERFORMANCE](#) [RESEARCH](#) [GP AREA](#)



YOU ARE HERE: [HOME](#) > [A-Z OF SERVICES](#) > [WALK-IN CENTRES](#) > [LIVERPOOL CITY CENTRE NHS WALK-IN CENTRE](#)

> WALK-IN CENTRES

[Litherland NHS Walk-in Centre](#)

[Old Swan NHS Walk-in Centre](#)

[Liverpool City Centre NHS Walk-in Centre](#)

[Smithdown Children's NHS Walk-in Centre](#)

[South Liverpool NHS Walk-in Centre](#)

LIVERPOOL CITY CENTRE NHS WALK-IN CENTRE

> WHAT WE DO

Liverpool City Centre Walk-in provides consultations, advice and treatment for minor injuries and illnesses, examples include: minor infections and rashes, stomach upsets, superficial cuts and bruises, strains and sprains, coughs, colds and flu-like symptoms. Also provided is emergency contraception and advice and Chlamydia screening for under 25's.

After booking in at reception you will be seen by a triage nurse who will assess the priority of your condition and ensure you are safe to wait in the department.

According to your priority you will then receive a more detailed consultation from another Nurse Practitioner.

We aim to see all patients as quickly as possible, however please bear in mind that waiting times will vary according to the number of patients booking in at any one time.

Patients will be seen in order of priority and not necessarily in order of arrival and booking in.

Appendix 12: Ethics form for Liverpool tourists study



Research Ethics Committee Application

Application for Ethical Approval of Undergraduate, Postgraduate or Staff Research involving Human Participants or the Use of Personal Data

Where research involving human participants or databases of personal information is being conducted by a member of staff or student LJMU Research Ethics Committee (REC) considers and advises researchers on the ethical implications of their study.

No research must be started without full, unconditional ethical approval.

Applications must be made using this form and must be typed. Please note that the only valid version of this application form is the current version found online. Previous versions will not be accepted.

Guidance on completing this form can be found at

<http://www.ljmu.ac.uk/RGSO/93717.htm>

Applications, inclusive of specified attachments, can be emailed to LJMU REC via researchethics@ljmu.ac.uk. A paper copy of the signature page only must also be sent to the Research Ethics Administrator, Research Support Office, Rodney House. Applications must be received by the submission dates published on the RSO website.

Where a University research project is to be undertaken using NHS patients, staff or resources or

the work must undergo ethical review via the National Research Ethics Service (NRES). University staff or students undertaking such research need not complete this form but must submit a completed [LJMU Research Governance Proforma](#) and provide LJMU REC with written evidence of full, unconditional ethical approval from NRES prior to commencing their research. On receiving confirmation of NRES ethical approval formal notification of LJMU REC approval will be issued via Chair's action.

Where teaching practices involve invasive (psychological or physiological) procedures on human participants staff should refer to the guidance provided at <http://www.ljmu.ac.uk/RGSO/93087.htm> regarding the development of departmental/faculty codes of practice. Codes of Practice will receive blanket approval for a period of 5 years from LJMU REC.

Potential participants must not be contacted until written approval has been received from the LJMU REC.

Application for Ethical Approval of Research Involving Human Participants

Research Mode

<input type="checkbox"/>	Undergraduate – specify course	
<input type="checkbox"/>	Postgraduate	
<input type="checkbox"/>	MRes,	
<input type="checkbox"/>	MPhil,	
<input checked="" type="checkbox"/>	PhD	
<input type="checkbox"/>	Prof Doc	
<input type="checkbox"/>	Other – please specify	

<input type="checkbox"/>	Postdoctoral
<input type="checkbox"/>	Staff project
<input type="checkbox"/>	Other – please specify

Has this application previously been submitted to the University REC for review? – No

If yes please state the original REC and,

Ref Number

the date of the REC meeting at which it was last

reviewed

Section A – The Applicant

A1a. Title of the Research

The sexual health and related risk behaviours of international tourists visiting the UK

A2. Principal Investigator (PI) (*Note that the in the case of postgraduate or undergraduate research the student is designated the PI. For research undertaken by staff inclusive of postdoctoral researchers and research assistants the staff member conducting the research is designated the PI.*)

Title Forename Surname

Post

Department / School / Faculty

Email Telephone

Relevant experience / Qualifications

September 2003-June 2008	<u>University of Edinburgh</u> M.A Honours Social Anthropology 2.1
September 1996- June 2003	<u>Whickham Comprehensive</u> A level: Business Studies A English Language A Sociology A (AQA)
May 2009-	Integrated Research Methods (module)
June 2009-	An introduction to SPSS (module)
Completion of Viva examination for transfer from MPhil- PhD March 2011	

A3. Co-applicants (including student supervisors)

Co-applicant 1

Title *Prof* Forename *Mark* Surname *Bellis*

Post *Director*

Department / School / Faculty *Faculty of Health and Applied Social Sciences*

Email *M.A.Bellis@ljmu.ac.uk* Telephone *0151 231 4511*

Relevant experience / Qualifications

Director of the Centre for Public Health, LJMU, the North West Public Health Observatory and the World Health Organization Collaborating Centre for Violence Prevention. Heads a team of academics and health professionals on national and international projects addressing alcohol and drug use, sexual behaviour, violence, and public health intelligence. He has been an expert advisor on drug prevention to both the United Nations (UNODC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Mark is currently the lead academic for the UK Drugs Focal Point and IREFREA - a European Union collaborative examining substance use (alcohol and drugs), sexual risk taking and prevention in young people across Europe. Professor Bellis is a founding member of Club Health (www.clubhealth.org.uk), an international initiative sharing good practice on nightlife health.

Co-applicant 2

Title *Miss* Forename *Karen* Surname *Hughes*

Post *Reader, Behavioural Epidemiology*

Department / School / Faculty *Faculty of Health and Applied Social Sciences*

Email *K.E.Hughes@ljmu.ac.uk* Telephone *0151 231 4453*

Relevant experience / Qualifications

BSc, Development Studies, Coventry University (2:1)

MPhil, Behavioural Epidemiology, Liverpool John Moores University

I have twelve years of experience of conducting original quantitative and qualitative research into the risk behaviour of young people, including in both nightlife environments and international holiday resorts. I have worked at the Centre for Public Health as a researcher since 1999 and I am currently working on issues including alcohol use, sexual behaviour, recreational drug use and violence.

Co-applicant 3

Title **Dr** Forename **Diana** Surname **Leighton**

Post **Research Excellence Framework Manager**

Department / School / Faculty **Research Support Office (Office of Academic Enhancement, Research and Regional Engagement)**

Email **d.j.leighton@ljmu.ac.uk** Telephone **0151 904 6472**

Relevant experience / Qualifications

BSc (Hons, Sports Science); PhD (Epidemiology of Back Pain); postdoctoral research experience in health/occupational health; MBA. Currently enrolled on LJMU's Doctorate in Business Administration programme.

Where there are more than 3 co-applicants please append an additional page to your application containing the relevant details

SECTION B – PROJECT DETAILS

B1. Proposed Study Dates

Start Date	30/07/11
End Date	30/08/11

B2. Scientific Justification. State the background and why this is an important area for research (*Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4*)

Previous studies have focused on the behaviour of British tourists in holiday destinations, such as Australia (Bellis et al 2007; Hughes et al 2009); and have shown increased levels of risky sexual behaviour, drug and alcohol use. However large numbers of international tourists arrive in the UK every year, and many will take part in British nightlife environments.

There is little known about the sexual behaviour, alcohol and drug use of tourists visiting the UK, and if they experience the same risks as young Brits abroad. The UK has among the highest levels of alcohol and drug use by young people in Europe; yet to date no study has examined whether exposure to UK nightlife environments influences the behaviour of young people visiting from other countries.

The UK can be seen as having a culture of alcohol abuse and ‘binge drinking’, particularly in young people visiting bars and nightclubs. The health effects of which can lead to instances of risky sex, longer term heart and liver problems, as well as increases in anti-social behaviour. Recent research of young people in the UK has highlighted that misuse of alcohol can lead to increased levels of violence and injury, substantially contributing to the number of people visiting health services, such as Accident and Emergency departments (Hughes et al 2008; Quigg et al 2010).

Similarly to young British people travelling abroad, international tourists may be exposed to different types of drugs and drug use in the UK, as well as increased opportunities for casual sex. Consequently, this introduces new types of health risks in an unfamiliar foreign environment.

International travellers come from a variety of cultures with differing social and moral codes surrounding the use of substances and sexual behaviour. Therefore, it is unclear to what extent tourists are influenced by drug and alcohol related behaviour in the UK, and how much their sexual behaviour and attitudes may change as a result of this. It is important to understand the burden that international travellers may have on UK health services, and also the potential for future health initiatives around sexual health and substance use.

B3. Give a summary of the purpose, design and methodology of the planned research

(Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4)

Objectives:

- To measure the sexual behaviour, substance use and related risk behaviours of young international tourists visiting UK destinations.
- To identify the sexual health, substance use and any related services needed for young international tourists visiting destinations in the UK.
- To understand the burden that international tourist may have on UK health services.

Methodology

The study would compare the behaviour of individuals whilst in the UK, and previously at home, looking in particular at:

- Levels of drug and alcohol use
- Levels of sexual behaviour.
- Use of health services in the UK, specifically substance use and sexual health services.
- Attendance at nightlife venues such as bars and nightclubs
- Healthcare literature and information received on arrival and during their stay.

Method

A quantitative questionnaire would be used similar to those previously used in studies of British tourists (Bellis et al 2004; 2007; Hughes et al 2009). The proposed research would involve an airport study targeting international tourists on their return journey from the UK, and would use self administered questionnaires.

Recruitment of sample

The target sample will be young tourists, aged 16-35, returning from a holiday spent in the UK from the most prominent nationalities. The sample will be selected using airport data to identify nationalities; this will be based on the number of flights to a destination and the consideration of types of passengers that come to the UK from different countries. The target sample size will be 300 individuals.

B4. State the principal research question

The sexual health and related risk behaviours of international tourists visiting the UK

B5a. Give details of the intervention(s) or procedure(s) to be received by participants (including psychological or physical interventions, interviews, observations or questionnaires)

Intervention	Numbers per individual participant	Avg. Time / Intervention / participant	Is this a novel procedure?
<i>Questionnaire</i>	<i>150</i>	<i>5minutes</i>	<i>no</i>

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

B5b. Where questionnaires are to be used have these previously been validated?

☒ Yes ☐ No ☐ Not Applicable

If yes, state by whom and when. If no, you must append copies of the questionnaire to this application.

The questionnaire is based on previously validated questionnaires used in a range of research projects of holidaymakers' risk behaviour abroad. Additional questions have been added to meet the needs of this research project. A copy of the questionnaire is enclosed.

B5c. Where interviews (structured or semi-structured) are proposed you must append an outline of the interview schedule to this application.

B6. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting or is it possible that criminal or other disclosures requiring action could take place during the study? (e.g during interviews or focus groups)

☒ Yes ☐ No ☐ Not Applicable

If yes give details of procedures in place to deal with these issues. Information given to participants should make it clear under what circumstances action may be taken

Questionnaires will include the topics of drug and alcohol consumption, as well as sexual activity. Participants will be fully informed of the nature of the questionnaire. All questionnaires will be confidential and kept anonymous to further deal with sensitivity or embarrassment.

B7. Where will the intervention take place? (ie LJMU premises, participants' homes, public places etc)

At Liverpool John Lennon Airport

B8. How will the findings of the research be disseminated?

In addition to the PhD thesis, the findings will be prepared for peer reviewed publication in a relevant journal.

SECTION C – THE PARTICIPANTS

C1a. Identify the participants for the study (LJMU staff, LJMU students, members of the public, other please specify)

International holidaymakers who have visited the UK.

C1b. How will the participants been selected, approached and recruited? If participants are to be approached by letter/email please append a copy of the letter/email.

Participants will be approached opportunistically Liverpool John Lennon Airport at the departure area and asked if they would like/have time to fill in a short questionnaire. The selection criteria will be international tourists aged 16-35 on their return journey to their country of origin.

C2a. What is the total number of participants?

300

C2b. How was this number decided?

Based on previous research studies of this nature, the number was considered to be an appropriate amount to provide a meaningful quantitative analysis, yet also achievable within the data collection period.

C3a. Will any of the participants come from any of the following groups? (Please tick all that apply)

Please note that the Mental Capacity Act 2005 requires that all research involving participation of any adult who lacks the capacity to consent through learning difficulties, brain injury or mental health problems be reviewed by an ethics committee operating under the National Research Ethics Service (NRES). For further information please see <http://www.ljmu.ac.uk/RGSO/101579.htm>

<input type="checkbox"/>	Children under 16
<input type="checkbox"/>	Adults with learning disabilities
<input type="checkbox"/>	Adults with mental illness (if yes please specify type of illness below)
<input checked="" type="checkbox"/>	Drug / Substance users
<input type="checkbox"/>	Young offenders
<input type="checkbox"/>	Those with a dependant relationship with the investigator
<input type="checkbox"/>	Other vulnerable groups please specify

Justify their inclusion

The inclusion of drug/substance users is vital to the nature of the question.

C3b. If you are proposing to undertake a research study involving interaction with children do you have current, valid clearance from the Criminal Records Bureau (CRB)

Not applicable

C4a. What are the inclusion criteria?

Being an international tourist aged 16-35 who has visited the UK in August 2011.

C4b. What are the exclusion criteria?

Being British and being outside of the age limits. Being a resident in the UK.

C5. Will any payments/rewards or out of pocket expenses be made to participants?

☐ Yes ☒ No

If yes what or how much?

SECTION D – CONSENT

D1. Will informed consent be obtained from (please tick all that apply)

<input checked="checked" type="checkbox"/>	The research participants?
<input type="checkbox"/>	The research participants, carers or guardians?
<input type="checkbox"/>	Gatekeepers to the research participants? (ie school authorities, treatment service providers)

D2. Will a signed record of consent be obtained? Please note that were the study involves the administration of a questionnaire or survey a signed record of consent is not required for completion of the questionnaire as long as it is made clear in the information sheet that completion of the questionnaire is voluntary. Under these circumstances return of the completed questionnaire is taken as implied consent.

In such cases the REC would expect a statement to be included at the start of the questionnaire where the respondent confirms that they have read the participant information sheet and are happy to complete the questionnaire.

Participation in any other interventions within the same study eg interviews, focus groups must be supported by obtaining appropriate written consent.

<input checked="checked" type="checkbox"/>	Yes	<input type="checkbox"/>	No
--	-----	--------------------------	----

The participants of the questionnaire will not sign a record of consent. However an information sheet will be provided to all participants and informed consent will be gained verbally, with compliance recorded by the researcher.

D3. Will participants, and where applicable, carers, guardians or gatekeepers be provided with an information sheet regarding the nature, purpose, risks and benefits of the study?

<input checked="checked" type="checkbox"/>	Yes	<input type="checkbox"/>	No
--	-----	--------------------------	----

If no please explain why not

D4. Will participants be able to withhold consent or withdraw consent to the procedure?

☒ Yes ☐ No

If no please explain why not

SECTION E - RISKS AND BENEFITS (Where risks are identified an LJMU risk assessment form must be completed)

E1. Describe in detail any potential adverse effects, risks or hazards, including any discomfort, distress or inconvenience, of involvement in the study for research participants. *Explain any risk management procedures which will be put in place.*

Potential adverse effect to the participant may come from the disclosure of personal information about sexual activity and substance use. However the nature of the study will be clearly explained prior to completion of the questionnaire.

E2. Explain any potential benefits of the proposed intervention for individual participants.

The researcher will be actively seeking information on health service provision and availability in the UK and abroad. Individuals involved in the questionnaires may benefit from knowledge gained through this process.

E3. Describe in detail any potential adverse effects, risks or hazards (mild, moderate, high or severe) of involvement in the research for the researchers. *Explain any risk management procedures which will be put in place.*

There is the potential for aggression from participants towards the researcher however this is minimal. Participation is voluntary and can be withdrawn at any time.

We will seek the appropriate permission from the airport and follow the necessary guidance of airport security staff. The researcher will be accompanied by another research assistant or supervisor at all times.

SECTION F – DATA ACCESS AND STORAGE

F1. Will the study involve any of the following activities at any stage (please tick all that apply)

Applicants should note that no personal identifiable information or sensitive information relating to participants should be transferred in or out of the EU without the consent of participants. Similarly where the use of verbatim quotes is proposed in future publications or presentations or it is intended that information is gathered using audio/visual recording devices explicit consent for this must be sought from participants.

<input type="checkbox"/>	Electronic transfer of data by magnetic or optical media, email or computer networks
<input type="checkbox"/>	Sharing of data with other organisations
<input type="checkbox"/>	Export of data outside of the European Union
<input type="checkbox"/>	Use of personal addresses, postcodes, faxes, emails or telephone numbers
<input checked="" type="checkbox"/>	Publication of direct quotations from respondents
<input type="checkbox"/>	Publication of data that might allow identification of individuals
<input type="checkbox"/>	Use of audio/visual recording devices

Storage of personal data on any of the following:

<input type="checkbox"/>	Manual files
<input type="checkbox"/>	Home or personal computers
<input type="checkbox"/>	Private company computers
<input checked="" type="checkbox"/>	Laptop computers

Applicants should note that only in exceptional circumstances will the storage of personal identifiable or sensitive information relating to participants on home or laptop computers or private company computers.

What measures have been put in place to ensure confidentiality of personal data (eg password protected files, encryption or other anonymisation procedures)? If you have checked any of the boxes above please provide justification for such activity.

Only the participants age, sex and country of origin will be recorded, the participant will not give their name or contact details to ensure the data is anonymous. The collected data will be entered into a password protected computer on LJMU premises.

F2. Who will have control of and act as custodian for the data generated during the procedure?

The Applicant

F3. Who will have access to the data generated?

The applicant and co-applicants

F4. For how long will data for the study be stored?

Until research findings are published (or to a maximum of five years).

Once you have completed the above application form please submit it electronically to researchethics@ljam.ac.uk. *If possible please submit your application form and any additional supporting documentation as a single pdf file.*

Both you and your supervisor or school director must sign the signature page below, complete the checklist of documents sent electronically and send a paper copy of the following 2 pages only to the Research Ethics Administrator, Research Support Office, Rodney House, 70 Mount Pleasant, Liverpool L3 5UX.

Please ensure that you complete the summary project details below to ensure that your signature page can be associated with your electronic submission for approval.

Title of the Research Study

The sexual health and related risk behaviours of international tourists visiting the UK

Principal Investigator (PI)

Title **Miss** Forename **Danielle** Surname **Kelly**

For RSO use only

Date received	Initials	LJMU REC Ref

DECLARATION OF THE PRINCIPAL INVESTIGATOR / SUPERVISOR / STUDENT

The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

I undertake to abide by the ethical principles underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.

If the research is approved I undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.

I undertake to seek an ethical opinion from LJMU REC before implementing substantial amendments to the approved study plan.

If, in the course of the administering any approved intervention, there are any serious adverse events, I understand that I am responsible for immediately stopping the intervention and alerting LJMU REC.

I am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.

I understand that any records/data may be subject to inspection for audit purposes if required in the future.

I understand that personal data about me as a researcher will be held by the University and this will be managed according to the principals of the Data Protection Act.

I understand that the information contained in this application, any supporting documentation and all correspondence with LJMU REC relating to the application will be subject to the provisions of the Freedom of Information Act. The information may be disclosed in response to requests made under the Act except where statutory exemptions apply.

I understand that all conditions apply to my co-applicants and other researchers involved in the study and that it is my responsibility that they abide by them.

Signature of Principal Investigator

--

Date

--

Print Name

Danielle Kelly

Signature of Supervisor / School Director or nominee

--

Date

--

Print Name

Karen Hughes

CHECKLIST OF DOCUMENTS SUBMITTED ELECTRONICALLY (Please tick relevant boxes)

<input checked="" type="checkbox"/>	Ethics Application Form (MANDATORY)
<input checked="" type="checkbox"/>	Protocol (MANDATORY) see note below
<input type="checkbox"/>	Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
<input checked="" type="checkbox"/>	Participant Information Sheet
<input type="checkbox"/>	Carer Information Sheet
<input type="checkbox"/>	Gatekeeper Information Sheet
<input type="checkbox"/>	Participant Consent Form
<input type="checkbox"/>	Carer Consent Form
<input type="checkbox"/>	Gatekeeper Consent Form
<input checked="" type="checkbox"/>	Non-validated questionnaires
<input type="checkbox"/>	Interview schedule
<input checked="" type="checkbox"/>	Risk Assessment Form

	Other please specify

Note

A research protocol is a document describing in detail how a research study is to be conducted in practice, including a brief introduction or background to the study, the proposed methodology and a plan for analysing the results. For the purposes of your application for ethical approval it is something which can be presented in a variety of formats dependent on its origin for example:

- *for postgraduate research students it may be the programme of work embedded within their programme registration form (RD9R)*
- *for studies which have obtained external funding it is often the description of what they propose doing which they submitted to the funder*
- *for other students it is the study proposal they have written and had assessed/approved by their supervisor.*

Appendix 13: Translations of Liverpool Tourists questionnaire into Dutch, French, German and Spanish

DUTCH

Seksuele gezondheid UK 2011

1. Hoe oud bent u? 2. Wat is uw geslacht? ☐ Man ☐ Vrouw

3. In welk land woont u?

4. Wat was de lengte van uw verblijf in de UK tijdens deze trip? dagen

5. Waar heeft u tijdens deze trip voornamelijk verbleven in de UK? (Bijv. Liverpool)

6. Waarom hebt u gekozen voor een bezoek aan de UK? (meerdere antwoorden mogelijk)

Cultuur <input type="checkbox"/>	Uitgaan <input type="checkbox"/>	Festival/evenement <input type="checkbox"/>
Weer <input type="checkbox"/>	Werk <input type="checkbox"/>	Drugs <input type="checkbox"/>
Seks <input type="checkbox"/>	Muziek <input type="checkbox"/>	Bezoek aan Familie/Vrienden <input type="checkbox"/>

Anders, nl

7. Met hoeveel mensen bent u naar de UK geweest?

Mannen Vrouwen

8. Hoeveel avonden bent u uitgeweest in een bar of nachtclub tijdens uw trip in de UK?

Bar Disco/nachtclub

9. Hoe vaak heeft u een van de onderstaande middelen gebruikt tijdens deze trip naar de UK?

Als U langer dan een week in de UK hebt doorgebracht, kruis dan een van de onderstaande hokjes aan.

	Nooit	Minder dan één keer per week	Eén keer per week	2-4 dagen per week	5 of meer dagen per week	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Tabak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen
Anders,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> dagen

namelijk:

Als u korter dan een week in de UK heeft doorgebracht, geef dan in onderstaande hokjes aan hoeveel dagen u een middel heeft gebruikt.

10. Als u alcohol heeft gedronken in de UK, op hoeveel dagen was u dronken? dagen

11. Heeft u tijdens uw verblijf in de UK genotsmiddelen gebruikt die u nooit eerder had gebruikt?

Ja ☐ Nee ☐

Zo ja, welke?

12. Zijn aan u genotsmiddelen aangeboden tijdens uw verblijf in de UK?

Ja ☐ Nee ☐

Zo ja, welke?

13. Als u genotsmiddelen heeft gebruikt tijdens uw verblijf in de UK, heeft u ze dan:

Meegenomen naar de UK ☐

Verkregen in de UK ☐

14. Hoe vaak gebruikt u thuis onderstaande middelen? (geef dit aan voor elk middel)

	Nooit	Weteens gebruikt, maar niet in de afgelopen 12 maanden	Minder dan één keer per maand	1-3 keer per maand	Eén keer per week	2-4 dagen per week	5 of meer dagen per week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tabak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anders,	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Namelijk:

15. Bent u naar de UK gekomen met een seksuele partner of echtgeno(o)t(e)?

Yes ☐ No ☐

16. Met hoeveel mensen heeft u seks gehad tijdens uw verblijf in de UK?

Mannen Vrouwen

17. Als u seks heeft gehad, hoeveel van uw sekspartners waren:

	Mannen	Vrouwen
Toeristen	<input type="text"/>	<input type="text"/>
Lokale inwoners	<input type="text"/>	<input type="text"/>
Anders,	<input type="text"/>	<input type="text"/>
Namelijk:	<input type="text"/>	

18. Met hoeveel hiervan heeft u altijd een condoom gebruikt?

Toeristen	<input type="text"/>
Lokale inwoners	<input type="text"/>
Anders	<input type="text"/>

19. Als u onveilige seks heeft gehad in de UK, was u toen onder de invloed van:

	Altijd	Soms	Nooit
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. Heeft u tijdens uw verblijf in de UK seks gehad waar u later spijt van had?

Ja Nee

21. Als u seks heeft gehad waar u later spijt van had, was u toen onder invloed van:

	Altijd	Soms	Nooit
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

22. Hoeveel seksuele partners heeft u de afgelopen 12 maanden gehad, voor u naar de UK kwam?

23. Heeft u reisgezondheidsadvies of informatie gekregen voor uw trip naar de UK ?

Ja Nee

Zo ja, was dit:

Advies over alcohol

Advies over drugs

Advies over seksuele gezondheid

24. Heeft u tijdens uw verblijf het ziekenhuis of een dokter moeten bezoeken?

Ja Nee

Zo ja, was dit:

Alcoholgerelateerd

Drugserelateerd

Sekserelateerd

Anders

25. Tijdens uw verblijf in de UK, heeft u of uw partner gebruik gemaakt van:

Een morning after pill

Een SOA-test

Een zwangerschapstest

26. Heeft u tijdens uw verblijf in de UK gezondheidsinformatie gekregen over de volgende onderwerpen?

Drugs

Alcohol

Seksuele gezondheid

27. Bent u naar aanleiding van uw verblijf in de UK van plan om een SOA-test te laten doen als u thuis komt?

Ja Nee

Bedankt voor uw medewerking

Voor aanvullende informatie over dit onderzoek kunt u mailen naar Danielle Kelly op D.Kelly@lmu.ac.uk.



Vacances de la Santé UK 2011

1. Quel âge as-tu? 2. Es-tu un homme ☐ ou une femme? ☐ Masculins Féminine

3. Quel est ton pays de résidence?

4. Au cours de ce voyage, combien de jours as-tu passé au Royaume-Uni? jours

5. Sur ce voyage au Royaume-Uni, dans quelle ville as-tu passé la plupart de ton temps?

6. Pourquoi as-tu choisi de venir au Royaume-Uni?:

La culture ☐ Le sexe ☐ Un festival/un événement ☐
 La musique ☐ Les drogues ☐ Les activités nocturnes ☐
 Le temps ☐ Le travail ☐ Rendre visite des amis ou la famille ☐

Autre (spécifie)

7. Avec combien de personnes as-tu voyagé au Royaume-Uni?

les mâles

femelles

8. Sur ce voyage au Royaume-Uni, combien de nuits as-tu passé dans un bar ou un club?

Un bar

Un club

9. Durant ce séjour au Royaume-Uni, combien de fois as-tu pris ces substances?

Si tu as passé plus d'une semaine ici?

	Jamais	Moins d'une fois par semaine	Une fois par semaine	Entre 2 et 4 jours par semaine	Au moins 5 fois par semaine
L'alcool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Le tabac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Le cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L'extase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
La cocaïne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphétamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
La kétamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(spécifie)	<input type="text"/>				

Si tu as passé moins d'une semaine ici?

jours
 jours
 jours
 jours
 jours
 jours
 jours

10. Si tu as bu l'alcool au Royaume-Uni, à ton avis, combien de jours irais-tu que tu as été ivre? jours

11. Pendant que tu étais au RU, as-tu essayé de nouvelles drogues que tu n'avais pas testé auparavant?

Oui ☐

Non ☐

Quoi?

12. Tandis que dans le Royaume-Uni, avez-vous été offert la drogue?

Oui ☐

Non ☐

Quoi?

13. If you have used illegal drugs whilst in Liverpool, did you:

Bring them with you to the UK ☐

Purchase them in Liverpool ☐

Purchase them elsewhere ☐

14. While at home, how often do you normally use the substances listed below: (please tick the appropriate boxes)

	Never	Have, but not in the last 12 months	Less than once a month	1-3 times a month	Once a week	2-4 days a week	5 or more days a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(please specify)	<input type="text"/>						

15. Did you come to the UK with a sexual partner or spouse?

Yes ☐

No ☐

13. How many people have you have sex with during your stay in the UK?

Males Females

17. If you had sex, how many of your partners were:

	Males	Females
Tourists	<input type="text"/>	<input type="text"/>
Local residents	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>
(please specify)	<input type="text"/>	

18 With how many of these did you always use a condom?

Tourists

Local Residents

Other

19 If you had unprotected sex in the UK, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

20 Have you had sex whilst in the UK that you have later regretted?

Yes No

21 If you had regrettable sex, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drugs	<input type="text"/>	<input type="text"/>	<input type="text"/>

22 Before coming to the UK, how many sexual partners have you had in the past 12 months at home?

23 Did you receive any pre-travel health advice or literature before arriving in the UK?

Yes No

If yes, was it:

Advice about alcohol

Advice about drugs

Advice about sexual health

24. Have you had to go to the hospital or doctors during your stay in the UK?

Yes No

If yes, was it:

Alcohol related

Drug related

Sex related

Other

25. Whilst in the UK, have you or your partner required any of the following?

Emergency contraception

Sexual health check up

Pregnancy testing

26. Whilst in the UK, have you received any health information on the following:

Drugs

Alcohol

Sexual health

27. Following your stay in the UK, do you intend to get a sexual health check up on your return home?

Yes No

Thank you for taking part

For further information about the study please contact Danielle Kelly at D.Kelly@ljam.ac.uk.



Umfrage zu Gesundheit im Urlaub – 2011

1. Dein Alter 2. Dein Geschlecht ☐ m ☐ w

3. In welchem Land befindet sich Dein ständiger Wohnsitz?

4. Wie viele Tage hast Du auf dieser Reise im Vereinigten Königreich verbracht? Tage

5. Wo hast Du Dich auf dieser Reise überwiegend aufgehalten? (z.B. Liverpool)

6. Warum hast Du Dich für eine Reise ins Vereinigte Königreich entschieden? (bitte alle zutreffenden Antworten ankreuzen)

Kultur ☐ Nachtleben ☐ Festival/Event ☐
Wetter ☐ Arbeit ☐ Drogen ☐
Sex ☐ Musik ☐ Freunde/Familie besuchen ☐

Sonstiges
(bitte angeben)

7. Mit wie vielen Personen bist Du ins Vereinigte Königreich gereist?

Männliche
Personen

Weibliche
Personen

8. An wie vielen Nächten während Deines Aufenthalts im Vereinigten Königreich hast Du eine Bar oder einen Nachtclub besucht?

Pub/Bar:

Nächte

Disco/
Nachtclub:

Nächte

9. Wie oft hast Du die folgenden Drogen während dieses Aufenthalts im Vereinigten Königreich konsumiert?

Falls Du eine Woche oder länger im Vereinigten Königreich warst, bitte kreuze unten die entsprechenden Antworten an

Falls Du weniger als eine Woche im Vereinigten Königreich warst, gib bitte unten an, an wie vielen Tagen Du während Deines Aufenthalts die folgenden Drogen konsumiert hast

	Gar nicht	Seltener als ein Mal pro Woche	Ein Mal pro Woche	An 2-4 Tagen pro Woche	An 5 Tagen pro Woche oder öfter	Tage
Alkohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Tabak/Nikotin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Kokain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Amphetamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ketamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Sonstige	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(bitte angeben)	<input type="text"/>					

10. Falls Du im Vereinigten Königreich Alkohol getrunken hast, an wie vielen Tagen während Deines Aufenthalts warst Du betrunken? Tage

11. Hast Du während Deines Aufenthalts im Vereinigten Königreich neue Drogen probiert, die Du vor diesem Aufenthalt noch nie genommen hattest?

Ja ☐

Nein ☐

Falls ja, welche?

12. Wurden Dir während Deines Aufenthalts im Vereinigten Königreich Drogen angeboten?

Ja ☐

Nein ☐

Falls ja, welche?

13. Falls Du während Deines Aufenthalts im Vereinigten Königreich Drogen konsumiert hast, hast Du diese ...

selbst ins Vereinigte Königreich mitgebracht? ☐

im Vereinigten Königreich gekauft? ☐

14. Wie oft konsumierst Du normalerweise (in Deinem Wohnsitzland) die folgenden Drogen? (bitte alle zutreffenden Antworten ankreuzen)

	Niemals	Habe konsumiert, aber nicht in den letzten 12 Monaten	Seltener als ein Mal pro Monat	1-3 Mal pro Monat	Ein Mal pro Woche	An 2-4 Tagen pro Woche	An 5 Tagen pro Woche oder öfter
Alkohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tabak/Nikotin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kokain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sonstige	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(bitte angeben)	<input type="text"/>						

15. Bist Du ins Vereinigte Königreich mit einem/einer Geschlechtspartner/in gereist (z.B. feste/r Freund/in, Ehepartner/in)?

Ja ☐

Nein ☐

16. Mit wie vielen Personen hattest Du während Deines Aufenthalts im Vereinigten Königreich Sex?

Männliche Personen	<input type="text"/>	Weibliche Personen	<input type="text"/>
--------------------	----------------------	--------------------	----------------------

17. Falls Du Sex hattest, wie viele Deiner Partner/innen waren:

	Männlich	Weiblich
Touristen	<input type="text"/>	<input type="text"/>
Einwohner	<input type="text"/>	<input type="text"/>
Andere	<input type="text"/>	<input type="text"/>
(bitte angeben)	<input type="text"/>	

18. Mit wie vielen dieser Geschlechtspartner/innen hast Du immer ein Kondom benutzt?

Touristen	<input type="text"/>
Einwohner	<input type="text"/>
Andere	<input type="text"/>

19. Falls Du im Vereinigten Königreich ungeschützten Sex hattest, warst Du unter dem Einfluss von:

	Immer	Manchmal	Nie
Alkohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drogen	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. Hattest Du während Deines Aufenthalts im Vereinigten Königreich Sex, den Du später bereut hast?

Ja	Nein
<input type="text"/>	<input type="text"/>

21. Falls Du während Deines Aufenthalts im Vereinigten Königreich Sex hattest, den Du später bereut hast, warst Du unter dem Einfluss von:

	Immer	Manchmal	Nie
Alkohol	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drogen	<input type="text"/>	<input type="text"/>	<input type="text"/>

22. Wie viele Geschlechtspartner/innen hattest Du in den letzten 12 Monaten bevor Du ins Vereinigte Königreich gereist bist?

23. Hast Du vor Deiner Ankunft im Vereinigten Königreich Gesundheitsinformationen zu Deiner Reise erhalten?

Ja	Nein
<input type="text"/>	<input type="text"/>

Falls ja, waren es:

Informationen zu Alkohol	<input type="text"/>
Informationen zu Drogen	<input type="text"/>
Informationen zu sexueller Gesundheit	<input type="text"/>

24. Musstest Du während Deines Aufenthalts im Vereinigten Königreich ein Krankenhaus oder einen Arzt aufsuchen?

Ja	Nein
<input type="text"/>	<input type="text"/>

Falls ja, war dieser Spitals- oder Arztbesuch bedingt durch:

Alkohol	<input type="text"/>
Drogen	<input type="text"/>
Geschlechtsverkehr	<input type="text"/>
Sonstiges	<input type="text"/>

25. Hast Du (oder hat Dein/e Partner/in) während des Aufenthalts im Vereinigten Königreich eine der folgenden Behandlungen oder Untersuchungen benötigt?

Notfallverhütung/ Pille danach	<input type="text"/>
Gynäkologische oder urologische Untersuchung	<input type="text"/>
Schwangerschaftstest	<input type="text"/>

26. Hast Du während Deines Aufenthalts im Vereinigten Königreich Gesundheitsinformationen zu folgenden Themen erhalten?

Drogen	<input type="text"/>
Alkohol	<input type="text"/>
Sexuelle Gesundheit	<input type="text"/>

27. Hast Du vor, Dich nach Deiner Heimreise gynäkologisch/urologisch untersuchen zu lassen? (z.B. auf sexuell übertragbare Krankheiten)

Ja	Nein
<input type="text"/>	<input type="text"/>

Vielen Dank für Deine Teilnahme

Für weitere Informationen zu dieser Studie wende Dich bitte per E-Mail an Danielle Kelly (D.Kelly@liverpool.ac.uk).



Vacaciones de Salud UK 2011

1. ¿Cuántos años tienes?

2. ¿Eres hombre o mujer? ☐ Masculino ☐ Femenino

3. ¿En qué país vives?

4. En este viaje, ¿cuántos días has pasado en el Reino Unido? días

5. En este viaje, ¿dónde has pasado la mayoría de tu tiempo?
¿En qué ciudad?

6. ¿Por qué elegiste venir al Reino Unido?

La cultura ☐ Las drogas ☐ Un festival/un evento ☐
El clima ☐ El trabajo ☐ La vida nocturna ☐
El sexo ☐ La música ☐ Para visitar a la familia/los amigos ☐
Otro ¿por qué?

7. ¿Con cuántas personas viniste al Reino Unido?

Los hombres Mujeres

8. En este viaje al Reino Unido, ¿cuántas noches has estado en un bar o una discoteca?

Bar Discoteca/ club nocturno

9. En este viaje al Reino Unido, ¿cuántas veces has tomado estas sustancias?

Si has pasado más de una semana aquí

	Nunca	Menos de una vez por semana	una vez por semana	Entre 2 y 4 veces por semana	5 veces o más por semana
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tabaco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
éxtasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cocaína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anfetaminas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ketamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
otro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¿cuál?

Si has pasado menos de una semana aquí

	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días
	<input type="text"/>	días

10. Si has bebido alcohol en Este viaje al Reino Unido, ¿cuántos días crees que te has emborrachado? días

11. En este viaje, ¿has probado o empezado a tomar alguna nueva sustancia?

Si ☐ No ☐

¿cuáles?

12. En el Reino Unido, ¿te han ofrecido alguna sustancia?

Si ☐ No ☐

¿cuáles?

13. Si has tomado alguna sustancia en el Reino Unido:

¿La trajiste contigo? ☐
¿La compraste aquí? ☐
¿comprar en otra parte? ☐

14. En tu propio país ¿cuántas veces tomas estas sustancias normalmente?

	Nunca	Lo he probado, pero no lo he tomado en los últimos 12 meses	Menos de una vez al mes	Entre 1 y 3 veces al mes	una vez por semana	Entre 2 y 4 veces a la semana	5 veces o mas a la semana
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tabaco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
éxtasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cocaína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anfetaminas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ketamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
otro	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¿cuál?

15. ¿viajaste al Reino Unido con un cónyuge o pareja sexual?

Si ☐ No ☐

16. En el Reino Unido, ¿con cuántas personas has tenido relaciones sexuales?

Los hombres Mujeres

17. Si has tenido relaciones sexuales, ¿cuántas de tus parejas han sido:

	Los hombres	Mujeres
Turistas?	<input type="text"/>	<input type="text"/>
Del Reino Unido	<input type="text"/>	<input type="text"/>
Otros	<input type="text"/>	<input type="text"/>
(Especifica)	<input type="text"/>	

18. ¿con cuántas de estas parejas usaste siempre condón?

Turistas	<input type="text"/>
residentes del Reino Unido	<input type="text"/>
Otros	<input type="text"/>

19. Si has tenido relaciones sexuales sin protección en el Reino Unido, ¿estabas bajo la influencia de:

	Siempre	A veces	Nunca
Alcohol?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drogas?	<input type="text"/>	<input type="text"/>	<input type="text"/>

20. En el Reino Unido ¿has tenido relaciones sexuales de las que te has arrepentido?

Si No

21. Si te has arrepentido de estas relaciones sexuales, ¿las tuviste cuándo estabas bajo la influencia de:

	Siempre	A veces	Nunca
Alcohol?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drogas?	<input type="text"/>	<input type="text"/>	<input type="text"/>

22. Antes de venir al Reino Unido, ¿cuántas parejas sexuales has tenido en los últimos 12 meses?

23. Antes de venir al Reino Unido, ¿recibiste algún consejo:

	Si	No
	<input type="text"/>	<input type="text"/>
Consejos sobre alcohol?	<input type="text"/>	<input type="text"/>
Consejos sobre drogas?	<input type="text"/>	<input type="text"/>
Consejos sobre la salud sexual?	<input type="text"/>	<input type="text"/>

24. En este viaje al Reino Unido ¿has tenido que ir al hospital o visitar al médico?

Si No

25. En este viaje al Reino Unido, tu pareja o tu, ¿habéis necesitado:

La pildora del día despues?	<input type="text"/>
Una revisión médica de salud sexual?	<input type="text"/>
Un test de embarazo?	<input type="text"/>

26. En el Reino Unido, ¿has recibido algún consejo sobre:

Alcohol?	<input type="text"/>
Drogas?	<input type="text"/>
Salud sexual?	<input type="text"/>

27. Después de este viaje al Reino Unido, ¿te harás una revisión médica de salud sexual cuando vuelvas a tu propio país?

Si No

Muchas gracias por tu participación.

Si tienes alguna pregunta no dudes en contactar con Danielle Kelly
D.Kelly@ljamu.ac.uk



Appendix 14: Liverpool tourists' study survey

Tourist Health UK 2011 (2)

1. How old are you? 2. What is your sex? ☐ Male ☐ Female

3. What is your country of residence?

4. On this trip, how many days have you spent in Liverpool? days

5. How many days in total are you staying in Liverpool? days

6. Why did you choose to visit Liverpool? (tick all that apply)

Culture <input type="checkbox"/>	Nightlife <input type="checkbox"/>	Festival/Event <input type="checkbox"/>
Weather <input type="checkbox"/>	Work <input type="checkbox"/>	Drugs <input type="checkbox"/>
Sex <input type="checkbox"/>	Music <input type="checkbox"/>	Visiting Family/Friends <input type="checkbox"/>

Other (please specify)

7. How many people did you travel to Liverpool with?

Males Females

8. On how many nights during your stay in Liverpool have you visited a bar or nightclub?

Pub/bar Disco/nightclub

9. During your stay in Liverpool, how frequently have you used the substances listed below?:

If you have stayed in Liverpool for a week or more, please tick the appropriate boxes below

	Never	Less than once a week	Once a week	2-4 days a week	5 or more days a week	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> days

(please specify)

If you have stayed in Liverpool for less than one week, please tell us on how many days of your stay you used each substance

10. If you have been drinking alcohol in Liverpool, on how many days of your stay would you say you had been drunk? days

11. Whilst in Liverpool, have you tried or started using any new substances that you had not previously used?

Yes ☐ No ☐

If yes, what?

12. Whilst in Liverpool, have you been offered any illegal drugs?

Yes ☐ No ☐

If yes, what substances?

13. If you have used illegal drugs whilst in Liverpool, did you:

Bring them with you to the UK ☐

Purchase them in Liverpool ☐

Purchase them elsewhere ☐

14. While at home, how often do you normally use the substances listed below: (please tick the appropriate boxes)

	Never	Have, but not in the last 12 months	Less than once a month	1-3 times a month	Once a week	2-4 days a week	5 or more days a week
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(please specify)

15. Did you come to Liverpool with a sexual partner or spouse?

Yes ☐ No ☐

16. How many people have you have sex with during your stay in Liverpool?

Males Females

17. If you had sex, how many of your partners were:

	Males	Females
Tourists	<input type="text"/>	<input type="text"/>
Local residents	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>
(please specify)	<input type="text"/>	

18. With how many of these did you always use a condom?

Tourists

Local Residents

Other

19. If you had unprotected sex in Liverpool, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Have you had sex whilst in Liverpool that you have later regretted?

Yes ☐ No ☐

21. If you had regrettable sex, were you under the influence of:

	Always	Sometimes	Never
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Before coming to Liverpool, how many sexual partners have you had in the past 12 months at home?

23. Did you receive any pre-travel health advice or literature before arriving in Liverpool?

Yes ☐ No ☐

If yes, was it:

Advice about alcohol ☐

Advice about drugs ☐

Advice about sexual health ☐

24. Have you had to go to the hospital or doctors during your stay in Liverpool?

Yes ☐ No ☐

If yes, was it:

Alcohol related ☐

Drug related ☐

Sex related ☐

Other ☐

25. Whilst in Liverpool, have you or your partner required any of the following?

Emergency contraception ☐

Sexual health check up ☐

Pregnancy testing ☐

26. Whilst in Liverpool, have you received any health information on the following:

Drugs ☐

Alcohol ☐

Sexual health ☐

27. Following your stay in Liverpool, do you intend to get a sexual health check up on your return home?

Yes ☐ No ☐

Thank you for taking part

For further information about the study please contact Danielle Kelly at D.Kelly@ljam.ac.uk.



Appendix 15: Published peer reviewed article from PhD findings: Kelly, D., Hughes, K., & Bellis, M. A. (2014). Work hard, party harder: drug use and sexual behaviour in young British casual workers in Ibiza, Spain. *International Journal of Environmental Research and Public Health*, 11(10), 10051-10061.

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Article

Work Hard, Party Harder: Drug Use and Sexual Behaviour in Young British Casual Workers in Ibiza, Spain

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Abstract: *Background:* Every summer, young people flock to nightlife-focused holiday resorts around the world to find casual work. Despite being exposed to hedonistic environments, often for several months, little is known about their substance use, sexual activity and health service needs over this extended amount of time abroad. *Methods:* A short anonymous questionnaire examining alcohol and drug use, sexual behaviour and use of health services was administered to young British casual workers aged 16–35 in San Antonio, Ibiza (n = 171). *Results:* 97.7% of casual workers used alcohol in Ibiza, and the majority (85.3%) used drugs. Almost half (43.5%) of all participants used a drug in Ibiza that they had never used in the UK. Most casual workers arrived in Ibiza without a partner or spouse (86.5%). Of these, 86.9% had sex during their stay and 50.0% had unprotected sex; often while under the influence of

alcohol. Only 14.3% of those having unprotected sex with a new partner sought a sexual health check-up in Ibiza, although 84.1% intended to do this on their return to the UK.

Conclusion: Substance use and sexual risk taking is widespread among young British casual workers in Ibiza. Such international nightlife resorts represent key settings for substance-related health and social problems, and for the international spread of sexually transmitted infections. Addressing the health needs of casual workers and the environments that permit and promote their excessive behaviour requires collaboration between authorities in home and destination countries and the tourism industry.

Keywords: drug use; alcohol; sexual behaviour; sexual health; casual workers

1. Introduction

Young people who holiday in nightlife-focused resorts often increase their engagement in health

risk behaviours during their stay, including alcohol use, drunkenness, drug use and risky sexual behaviour [1–3]. Holiday periods represent a time of excess and experimentation for young people, when they are free from usual social restraints and responsibilities and have increased opportunity to meet new people and try new things. Visiting a nightlife-focused holiday resort can submerge individuals in environments where hedonistic partying is the norm; alcohol is typically heavily promoted, drugs can be widely available and entertainment is often highly sexualised [4]. Sexual activity can increase due to increased opportunities to meet new sexual partners and the suspension of normal social codes, leading to accelerated sexual relationships [5–7]. In a study of young British holidaymakers visiting Majorca and Ibiza in Spain, for example, over a quarter of those travelling without a sexual partner had had sex during their stay and a third of these individuals had unprotected sex. Drunkenness was widespread in both locations but more common in Majorca, where 95% reported having been drunk at least once during their holiday and over 60% on five or more days per week. However, drug use was strongly associated with Ibiza, where over half of young holidaymakers reported having used at least one illicit drug during their stay [8].

In comparison to studies on tourists, relatively little research has focused on the substance use and sexual behaviour of young people who extend their stays in holiday resorts through casual work. Studies have shown that casual workers often remain in these hedonistic environments for several months working for bars, nightclubs or other tourism-related industries in international resorts such as Spain [9], Bulgaria [10], Australia [11] and the Caribbean [12]. Casual workers have been identified as instrumental mediators in both creating a social arena of risk and influencing the behaviours of tourists in nightlife resorts, promoting excessive alcohol and drug use and sexualised activities [4,10,13]. A study comparing British casual workers in Ibiza with tourists found that casual workers were more likely to be drug users; with a greater proportion having used drugs both during their stay in Ibiza and in the UK in the 12 months prior to

visiting the island. Although drug users who were casual workers used drugs less frequently than holidaymakers (likely due to the requirements of working), ecstasy at least, however, was consumed in greater quantities [9]. Increased levels of sexual risk taking were also found in casual workers, including unprotected sex and sex with multiple partners [13]. Casual workers therefore represent a high risk population that, due to their extended stay in a foreign country, is often beyond the reach of health services. Thus, here we examine substance use and sexual behaviour among young British casual workers in Ibiza, exploring use of new drugs in Ibiza, the involvement of alcohol in risky sexual behaviours and the use of health and sexual health services by casual workers.

2. Methods

A short questionnaire was developed based on a tool used previously in research [9,13]. The questionnaire measured casual workers' basic demographics, reasons for choosing to visit Ibiza, if they had previously worked on the island, length of current stay, type and hours of work, and frequency of substance use (alcohol, tobacco, cannabis, ecstasy, amphetamines, ketamine and gammahydroxybutyrate (GHB) in Ibiza and in the last 12 months spent in the UK. Sexual activity in Ibiza was measured through questions asking the number and type of sexual partners casual workers had whilst in Ibiza; their use of contraception with these partners; and whether participants had unprotected or regretted sex under the influence of alcohol or drugs. Participants were also asked how many sexual partners they had in the last 12 months in the UK.

The target sample was young British people (aged 16–35) working in San Antonio, Ibiza, in July/August 2009. Casual workers were defined as those working in bars, nightclubs, restaurants, hotels, as holiday reps, ticket sellers, or in any other tourism-related environment. Participants were approached opportunistically in areas frequented by casual workers, such as beaches and bars during the day and early evening (before 9 pm). Potential participants were asked if they had time to fill in a short questionnaire ($n = 221$); those who had time ($n = 199$) were informed about the nature of the study and that it was anonymous and confidential. Consent was obtained orally from those who were willing to take part ($n = 182$). Participants were handed a questionnaire on a clipboard, a pen and an envelope and asked to self-complete the questionnaire while the researcher stood a small distance away to maintain confidentiality, allowing the participant to ask questions if required. The participant was then told to place the completed questionnaire into a sealed envelope and return this to the researcher. All sealed envelopes were returned to the UK at the end of the study period for analysis. Participants were excluded if they had been in Ibiza for longer than six months ($n = 8$), to ensure that the sample represented only seasonal workers and not individuals who were living in Ibiza for longer periods of time. For the purpose of this analysis, three individuals that provided no information on substance use or sexual behaviour were also excluded, leaving a final sample of 171 casual workers. Data were

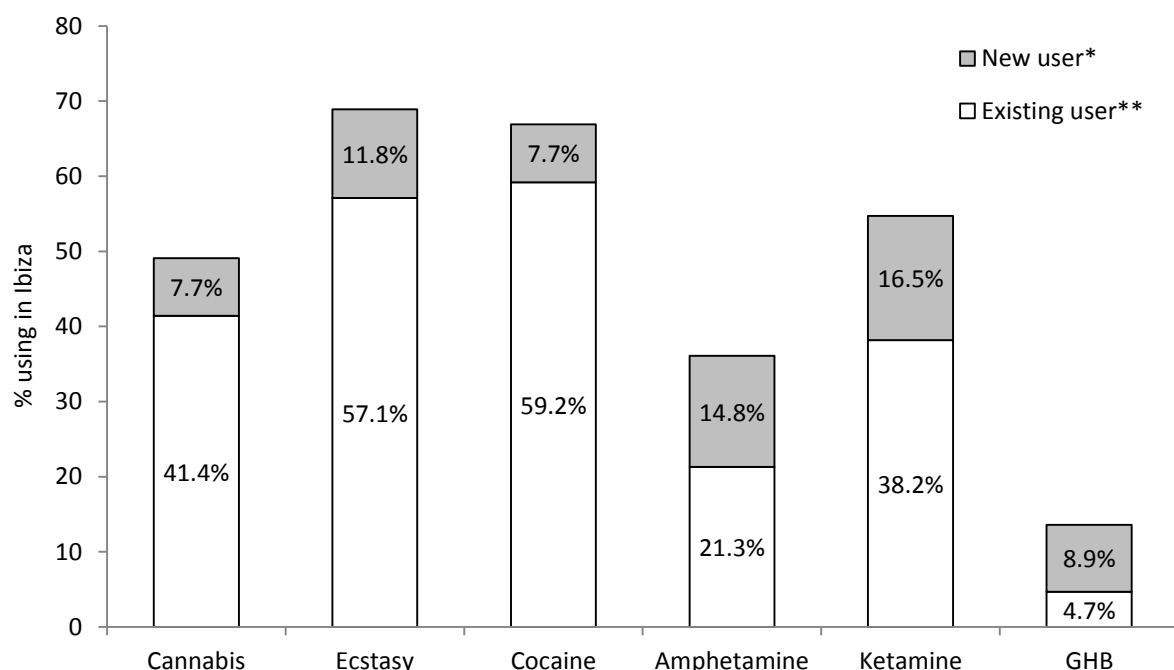
analysed using SPSS. Analysis used chi-squared and ANOVA with logistic regression to identify factors independently associated with sexual behaviour in Ibiza.

3. Results

Half of participants (52.6%) were female and mean age was 22.1 years. Mean length of stay in Ibiza at the point of survey was 10.3 weeks. Half (50.9%) of participants had worked in Ibiza previously. The most common occupations of casual workers in San Antonio were working in bars and nightclubs as waitresses or bar staff (30.4%), PR work promoting a bar or nightclub (24.0%) and selling tickets for nightclubs (18.1%), with a small percentage working in hotels or as holiday 'reps'. The most common reasons for choosing to work in Ibiza were for its nightlife (73.7%), music (73.1%) and weather (71.3%; multiple options could be selected). Males were more likely than females to have chosen Ibiza for its music (84.0% vs. 63.3%, $p = 0.002$) drugs (61.7% vs. 20.0%, $p < 0.001$) and sex (51.9% vs. 15.6%, $p < 0.001$). There were no gender differences in age, length of stay, total intended stay or previous seasons worked.

Most (97.7%) participants had consumed alcohol in Ibiza and 96.3% of drinkers reported getting drunk at least once a week. Half (54.1%) reported smoking tobacco and 85.3% using illicit drugs. There were no gender or age differences in substance use. The most common drugs used were ecstasy (68.8% of participants) and cocaine (66.9%), followed by ketamine (54.7%), cannabis (49.1%), amphetamines (36.1%) and GHB (13.6%). Most (87.6%) of those that used drugs in Ibiza used more than one type of drug, and many (50.7% of drug users, 43.5% of all participants) reported using drugs in Ibiza that they had never used in the UK (Figure 1). Across all participants, 16.5% used ketamine in Ibiza having never used in the UK, and for amphetamine and ecstasy these figures were 14.8% and 11.8%, respectively. For GHB, 15 of the 23 participants who had used in Ibiza had never used the drug in the UK. Amongst those reporting use of specific drugs in both UK and Ibiza, frequency of use increased in Ibiza. Thus, whilst 98.8% of ecstasy users stated using the drug \leq once a week in the UK, in Ibiza this fell to 59.5%, with 10.7% using the drug 5+ days a week (Table 1).

Figure 1. Prevalence of illicit drug use by casual workers in Ibiza, by new and existing drug users.



Note: * Never used the drug in the UK; ** Used the drug at least once in the UK.

The majority (86.5%, $n = 147$) of participants had travelled to Ibiza without a sexual partner (Table 2). Of those arriving with a sexual partner, 87.0% reported either one or no sexual partner in Ibiza. Thus, analysis of sexual behaviour was limited to the majority of participants arriving without a sexual partner. Of these single participants, 86.9% reported having sex in Ibiza and 71.7% reported more than one sexual partner. One hundred and twenty-six sexually-active single individuals provided further data on sexual activity. Half (50.0%) reported unprotected sex (without a condom) and a quarter (23.8%) reported unprotected sex with more than one partner. A third (37.3%) had sex that they later regretted. Over 90% of participants reporting either unprotected or regretted sex stated that they had been under the influence of alcohol when this occurred. Overall, participants' sexual partners were most commonly other workers or tourists (reported by 71.4% and 69.8% of single sexually active participants, respectively). Almost a third (30.4%) had sex with someone not from their country of residence and almost a fifth (18.3%) with a local resident. Of the participants that arrived in Ibiza without a sexual partner or spouse and had sex ($n = 126$), 9.5% ($n = 6$) had same-sex sexual activity during their stay. Of those 9.0% ($n = 6$) were female, and 10.2% ($n = 6$) were male. Further analyses with these data were not conducted due to the small sample sizes but are listed here for completeness.

Table 1. Frequency of substance use in UK and Ibiza among those using in both locations.

Substances Used	<i>n</i>	Alcohol	Tobacco	Cannabis	Ecstasy	Cocaine	Amphetamine	Ketamine
		165	81	62	84	87	32	50
Frequency of use UK %								
Once a week or less		42.4	19.8	70.5	98.8	93.1	100.0	98.0
2–4 days a week		47.3	11.1	18.0	1.2	5.7	0.0	2.0
5 or more days a week		10.3	69.1	11.5	0.0	1.1	0.0	0.0
Frequency of use Ibiza %								
Once a week or less		7.3	7.4	59.0	59.5	57.5	62.6	44.0
2–4 days a week		22.4	8.6	23.0	29.8	31.0	25.0	40.0
5 or more days a week		70.3	84.0	18.0	10.7	11.5	12.5	16.0
P between locations		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001

Note: GHB was not analysed due to low prevalence of use in UK.

In chi squared analysis, there were no associations between having sex, multiple sexual partners or unprotected sex and gender, age or employment characteristics. Longer length of stay was associated with having had sex and multiple partners (Table 2). Identifying music, drugs or sex as a reason for choosing to work in Ibiza was associated with having sex, whilst identifying sex as a reason was associated with multiple partners. Tobacco, cocaine and amphetamine use were associated with having sex, and amphetamine use with multiple partners. Illicit drug users were more likely to report sex and multiple sexual partners than non-users. Frequent drunkenness was strongly associated with both sex and multiple sexual partners. None of the factors examined had significant relationships with unprotected sex.

Factors with significant relationships in chi squared analysis were entered into logistic regression models. Here, odds of having sex were increased in those who: had been on the island for >10 weeks; identified sex as a reason for choosing to work in Ibiza; used amphetamines; and got drunk frequently. Odds of having multiple sexual partners were increased in those who: had been on the island >10 weeks; used tobacco; and got drunk frequently (Table 2).

Table 2. Factors associated with having sex and having multiple sexual partners among those arriving in Ibiza without a sexual partner *.

Variables	Variable Categories		Had Sex in Ibiza					
			%Yes ^a	X ²	<i>p</i>	AOR ^b	95%CIs	<i>p</i>
Time spent in Ibiza by point of interview	Up to 10 weeks		80.0			Ref		
	More than 10 weeks		95.4	7.455	0.006	9.62	2.10–43.98	0.004
Reasons for choosing to work in Ibiza	Sex	No	82.1	5.554	0.018	Ref		
		Yes	96.0			8.27	1.39–49.08	0.020
	Drugs	No	81.4	5.617	0.018			
		Yes	94.9					ns
	Music	No	74.4	7.365	0.007			
		Yes	91.5					ns
Substance use in Ibiza	Amphetamine	No	81.6	5.182	0.023	Ref		
		Yes	94.7			5.47	1.18–25.31	0.030
Number of illicit drugs used	None		66.7					
	1–3		88.3					
	4–6		90.6	7.221	0.027			ns
Frequency of drunkenness in Ibiza	≤once a week		66.7			Ref		0.008
	2–4 times a week		84.0			5.92	1.33–26.41	0.020
	5+ times a week		94.6	11.767	0.003	11.37	2.35–55.01	0.002
Had Multiple Sexual Partners in Ibiza								
			%Yes	X ²	<i>p</i>	AOR	95%CIs	<i>p</i>
Time spent in Ibiza by point of interview	Up to ten weeks		65.0			Ref		
	More than 10 weeks		80.0	3.979	0.046	2.56	1.05–6.26	0.039
Substance use in Ibiza	Tobacco	No	60.6			Ref		
		Yes	82.1	8.195	0.004	3.19	1.35–7.53	0.008
	Cocaine	No	60.0					
		Yes	77.0	4.422	0.035			ns
	Amphetamine	No	65.5					
		Yes	80.7	3.899	0.048			ns
Number of illicit drugs used	None		44.4					
	1–3		73.3					
	4–6		79.7	8.792	0.012			ns
Frequency of drunkenness in Ibiza	≤once a week		38.1			Ref		
	2–4 times a week		66.0			3.05	0.95–9.82	0.062
	5+ times a week		85.1	19.081	<0.001	11.62	3.41–39.65	<0.001

^a Chi squared analysis. Only factors with significant associations shown; ^b Logistic regression analysis including all factors shown; AOR = adjusted odds ratio; Ref = reference category.

Only 34.1% of participants reported having received any health information on drugs, alcohol or sexual health in Ibiza. Under a third (28.9%) had visited a doctor or hospital during their stay. Of individuals arriving without a sexual partner and having unprotected sex on the island,

only 14.3% reported having had a sexual health check-up in Ibiza. However, 84.1% reported that they would be seeking such a check-up on return to the UK.

4. Conclusion

Young casual workers in nightlife-focused resorts are a key at risk group for health and social harm. Among British casual workers in Ibiza, regular drunkenness was ubiquitous and 85.3% reported having used at least one illicit drug during their stay. Most casual workers used more than one drug type and around half had used a drug in Ibiza that they had never used in the UK. Given that casual workers were intending on staying an average 8.5 weeks longer on the island post-survey, this figure likely underestimates the actual prevalence of drug experimentation. Recruitment and relapse into drug use is a particular concern as individuals are likely to continue such levels of experimental drug use on return to the UK [2]. Most casual workers arrived in Ibiza without a partner or spouse and over two thirds of these reported having had more than one sexual partner by the time of interview. Half reported unprotected sex, which often occurred under the influence of alcohol. Despite such high levels of substance use and risky sexual behaviour, however, only 34.1% reported having received any relevant health information in Ibiza.

Scholars have previously commented that the behaviour of young tourists on holiday is simply an extension of leisure behaviours that take place at home every weekend [14,15], and this may be true of some holiday resorts. Nevertheless, the extended stay of casual workers in a heavily drug- influenced environment in Ibiza can act as a catalyst to the development of behaviours out of the ordinary, beyond those undertaken at home [4]. Ibiza's reputation as a major international dance music destination likely attracts high-risk young people already engaged in, or interested in, recreational drug use. In our study, 53.5% of casual workers reported use of ecstasy and 55.3% cocaine in the UK prior to visiting Ibiza; far higher than the past year prevalence of these substances reported among young people in the general UK population (in 2009/10, ecstasy 4.3%, cocaine 5.5%; Home Office, 2010) [16]. However, our findings suggest that the culture into which casual workers are immersed in Ibiza fosters tendencies towards risk behaviour. Many casual workers, particularly those working in nightlife-related industries, receive free entrance to nightclubs, discounted drinks and socialise in bars, nightclubs and staff accommodation blocks after work. With many casual workers returning to Ibiza year after year, new arrivals are likely to be rapidly integrated into a scene led by other high risk workers who use drugs and know how to find them. The wide availability and accessibility of drugs in Ibiza is emphasised by the high prevalence of use and experimentation identified here. Association with other high-risk casual workers, tourists and bar owners may invoke peer pressure to use drugs, while long working hours and routine late night partying could mean substance use becomes an essential part of maintaining the pace. The consequences of such progression would include declining physical and mental health, while in some cases low wages and high

social spend may lead to the supplementation of income through illicit means, including drug selling [4,17]. Despite this, there appears to be few relevant services available to advise, support or protect this high risk transient population, and few interventions to moderate their behaviour by authorities in either Ibiza or the UK.

In addition to the harms associated with drunkenness and involvement in drug cultures, our findings build on previous work identifying casual workers as being at high risk of sexual health problems [13]. Thus, we found that frequent drunkenness was a strong predictor of having multiple sexual partners and that sexual risk taking often occurred under the influence of alcohol. Alcohol use can facilitate sexual interactions by lowering inhibitions and raising confidence; yet at the same time reducing people's ability to make informed decisions about having sex and using contraception [18–20]. Thus, of those arriving without a sexual partner, 93.4% of those reporting unprotected sex and 97.8% of those reporting sex they later regretted said this had occurred whilst they were under the influence of alcohol. Increased involvement in frequent casual sexual relationships whilst abroad could potentially affect the behaviours of young people on return to the UK, as risky sexual activity becomes normalised. Whilst most sexual partners identified in our research were casual workers and tourists, research elsewhere has identified that that young tourists are engaging in sex with prostitutes and other sex workers [3,21]. For that reason, future research should explore whether casual workers are engaging in paid sex markets during their stay. Despite widespread sexual risk taking, however, few casual workers that had unprotected sex with a new partner had received a sexual health check-up in Ibiza; although the majority stated that they would seek such a check-up on return to the UK.

There may be numerous reasons for the failure of young people to access health services following unprotected sex, including a lack of available services to access; a lack of knowledge of, or trust in, foreign healthcare systems; a reluctance among young people to interrupt their fun with knowledge of a sexually transmitted infection (STI); or even nonchalance about the impact of contracting STIs. Chlamydia, the most common STI affecting young people in the UK [22], is easily treatable with antibiotics and can be viewed by young people as trivial [23]. Poor awareness of the differences between chlamydia and more serious conditions such as HIV [24] may mean this blasé attitude extends to STIs in general. However, the delay in obtaining a sexual health check up in a highly sexualised environment creates opportunity for the rapid spread of any STI, and with sexual mixing involving various nationalities and local residents, for their international dissemination. With infections such as syphilis and gonorrhoea increasing in Europe [25], and in particular the emergence of drug-resistant gonorrhoea [26], casual workers in international nightlife resorts should be viewed as a critical target population for sexual health interventions.

Our findings suggest a lack of health information available for young casual workers in Ibiza. Only around a third of participants had received information on sex, alcohol or drugs whilst in Ibiza, despite their length of stay by survey averaging over 10 weeks. With high levels of substance use, experimentation with new drugs and widespread sexual activity

among casual workers, the availability of information on health risks, harm reduction and where to go for health advice and treatment should be considered essential. Development and dissemination of such information should be co-ordinated through health and tourism authorities in both the host country and that of young people's country of residence. For example, as well as disseminating health-related materials in resorts themselves, advice and information could be targeted to young people through relevant websites and other media catering for those planning to work in an international nightlife resort. Broader strategies could include the development of staff training programmes for individuals working in holiday resorts, covering issues such as health, safety (both personal and within the workplace), legal issues, and availability of health and other services. Casual workers are key figures in promoting and maintaining risk environments and influencing the behaviours of tourists. If casual workers become more responsible for their individual health and wellbeing, for example drinking less alcohol, this could potentially reduce excessive behaviours amongst their peers.

Like all research into sensitive subjects, our study may have been affected by under- or over-reporting of substance use and sexual behaviour. However, to limit this effect participants were assured of their anonymity and provided with a method of completing the questionnaire in private and returning it to the researcher in an unmarked sealed envelope. Use of different illicit drugs was self-assessed and with widespread drug experimentation in Ibiza, it is possible that some participants may have misidentified substances. Equally, recall issues may have affected reports of substance use frequency in the UK in the 12 months prior to arriving in Ibiza. Finally, sampling was conducted on a convenience basis and focused only on British casual workers in the resort of San Antonio, thus findings cannot be generalised to all British casual workers in this resort. However, the study does give an important snap-shot of the behaviour of casual workers in one of the most popular nightlife resorts in the world. Findings highlight the need for greater focus on both the health of this high-risk population and the environmental factors that amplify their health harming behaviours.

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Author Contributions

Danielle Kelly created the study, and with the assistance of all co-authors carried out the research. The questionnaire was designed by Karen Hughes and Mark Bellis, and was read and approved by Danielle Kelly. Danielle Kelly was responsible for the recruitment of participants and the distribution of surveys in Ibiza. Danielle Kelly was responsible for the

cleaning of data and carrying out analyses, with the assistance of Karen Hughes and Mark Bellis. Danielle Kelly drafted the manuscript, with the final version read and approved by Karen Hughes and Mark Bellis.

Conflicts of Interest

The authors declare no conflict of interest.

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Appendix 16: List of conference abstracts where an oral presentation of PhD findings were delivered

‘The involvement of young British casual workers in drug dealing activities in San Antonio, Ibiza’ presented at the Club Health: 9th International Conference on Nightlife, Substance Use and Related Health Issues, Lisbon, June 2015

Background: Young British workers travel to Mediterranean holiday resorts every summer to take part in temporary casual employment. Previous studies have identified high levels of drug use within casual worker populations, however little is known about their involvement in existing drug markets operating in Ibiza.

Methods: Ethnographic fieldwork took place in San Antonio, Ibiza, over a one week period in July 2012. The research is based on participant observation and informal conversations held with young British casual workers living and working in the resort.

Findings: Low wages and competitive employment markets mean that individuals are increasingly becoming involved in low level drug dealing to fund their stay. High levels of inherent drug use in these environments, and pressure from peers, contributes to a permissive atmosphere whereby such deviant acts become normalised and acceptable.

Conclusion: Young British casual workers are a key target for intervention measures to prevent their involvement in illegal drug markets. Further research is needed to investigate the utilisation of casual workers for criminal means, and the extent to which casual workers are part of the wider network of drug dealing in Ibiza. Relevant criminal justice stakeholders and potential harm reduction services must be identified both locally in Ibiza and in the UK in order to provide adequate policy and active interventions.

‘Bridging the responsibility gaps for healthcare in an international tourist resort’ presented at the 8th International Conference on Nightlife, Substance Use and Related Health Issues, San Francisco, May 2013

Introduction: Ibiza is a globally notorious nightlife resort, attracting an influx of British tourists every summer who often engage in excessive drinking and substance use. Consequently, drug and alcohol related illness and injury place a major burden on Ibiza health services.

Method: The nightlife environment of San Antonio, Ibiza was explored, and the subsequent utilisation of health services for alcohol and drug related illness and injury. Ethnographic observations and informal conversations took place over a one week period in June 2012 with tourists, casual workers, healthcare providers and local authorities.

Results: The Ibiza tourism industry is under pressure to supply for the demands of young British tourists who arrive on youth package holidays expecting uninhibited partying, the best nightclubs and cheapest drinks. Additionally, many tourists arrive with the intention to use illicit drugs in dance music related environments. Subsequently leading to increases in alcohol and drug related illness and injury over the summer period of May until September. Public health clinics in Ibiza are operating over capacity and many facilities are not equipped to deal with anything more than basic health provisions due to lack of funding and

infrastructure. The complexities faced in providing sufficient healthcare for tourists are further exacerbated by the increasing use of private healthcare clinics, which charge large sums of money for treatment. As a result, tourists often lack access to affordable and efficient healthcare.

Conclusion: After consideration of the findings it is suggested that a balance is needed to reduce the burden on Ibiza health services. Relevant and responsible stakeholders from each country must be identified in order to work towards a more holistic approach when implementing harm reduction measures for young UK citizens in Ibiza.

‘The sexual behaviour and sexual health needs of young British casual workers in an international nightlife resort’ presented at the 7th International Conference on nightlife, Substance Use and Related Health Issues, Prague, December 2011

Background: Every year, young British people visit summer nightlife destinations with the intention to take part in casual work. Previous research has found increased use of illicit substances and sexual health risk in tourists (Bellis et al 2004; 2007), yet little is known about the longer term risks that casual workers face in resorts.

Method: A quantitative questionnaire was distributed in San Antonio, Ibiza to British casual workers aged 16-35 in summer 2009. The questionnaire looked at demographics, length of stay, type of work, levels of substance use and sexual activity, and levels of access to health services.

Findings: Analysis of findings used and SPSS database with Chi Squared and Wilcoxon signed rank testing. Around a third of participants visited Ibiza for the availability of sex (33.3%) and drugs (39.9%). 48.9% of those who had sex had unprotected sex and 46.7% had unprotected sex with more than one sexual partner. 83.6% of those were under the influence of alcohol at the time. 84.4% of casual workers reported using increased amounts of illicit drugs whilst in Ibiza compared with use in the UK. Only 33.3 % of participants had received any sexual health or drug use information, and only 10.4% had been for a sexual health check-up whilst in Ibiza.

Summary: Findings suggest that illicit substance use and risky sexual behavior are common features amongst young British casual workers in Ibiza. This is a concern due to the heightened risk of STI transmission and short and long term heart and liver problems. The risk is further increased due to the lack of health services available to the population of casual workers