Service provision and barriers to care for men who have sex with men engaging in chemsex and sexualised drug use in England

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Abstract

Background: Chemsex and sexualised drug use (SDU) among men who have sex with men (MSM) has become a public health issue because of its associated sexual risks. Some MSM engaging in SDU require further help and support, but it is not clear if this need is being met. This research seeks to understand MSM and service provider (SP) perspectives of the current standard of service provision for MSM engaging in SDU.

Method: Semi-structured interviews were conducted with 13 MSM and 16 SPs in England (January-December 2019). MSM who reported taking one of ten substances for sex in the past 12 months were recruited from a mailing list or a community organisation providing chemsex support. Potential SP participants were recruited via an email sent from their local healthcare NHS Trust. Data for MSM and SPs were analysed separately using thematic analysis.

Results: MSM participants had a median age of 34 years (range 23-66).The majority of SPs recruited were genitourinary medicine (GUM) consultants. We found that the main reason for engagement in SDU was because of the enhanced sexual experience. Most MSM recruited were satisfied with their sexual health service provision, but barriers to care were highlighted by both MSM and SPs. Four themes relating to barriers to care were identified: accessibility of sexual health services, funding of services, SP's attitudes towards MSM who engage in SDU, and services outside sexual healthcare.

Conclusion: SPs appeared to have adopted a harm reduction approach to MSM engaging in SDU, but for MSM wanting further help and assistance in relation to their SDU additional barriers to care existed. Training healthcare providers outside of sexual health services regarding chemsex and SDU may reduce some of these barriers, but funding for sexual health services needs to be improved to maintain and further develop services.

Keywords: men who have sex with men; chemsex; sexualised drug use; sexual health services; harm reduction

Introduction

Sexualised drug use (SDU), particularly chemsex, has become an emerging public health issue among men who have sex with men (MSM) due to associations with sexually transmitted infections (STI) diagnoses, living with HIV, condomless anal intercourse, having a higher number of sexual partners, serodiscordant anal intercourse, and injecting drug use (Blomquist et al., 2020; Bourne, Reid, Hickson, Torres Rueda, & Weatherburn, 2014; Glynn et al., 2018; Hegazi et al., 2017; Hibbert, Brett, Porcellato, & Hope, 2019; Ottaway, Finnerty, Buckingham, & Richardson, 2017). Chemsex in a United Kingdom (UK) context is a particular form of SDU, which involves the use of crystal methamphetamine, gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL), mephedrone, and/or ketamine taken immediately before or during sex to enhance the sexual experience (Bourne et al., 2014). Although there is variability in defining what drugs constitute as chemsex (Drysdale et al., 2020; Stuart, 2019), the use of crystal methamphetamine, GHB/GBL, mephedrone, and/or ketamine is commonly grouped as chemsex drugs in European research (Curtis et al., 2019; Rosińska et al., 2018; Schmidt et al., 2016). The rise in the number of men who have sex with men (MSM) engaging in chemsex has been attributed to the development of geospatial networking applications and online sites used to meet sexual partners (Ahmed et al., 2016; Stuart, 2013). Studies have estimated that around 1 in 5 MSM in London may have engaged in chemsex during the past year, and this proportion has remained stable between 2013-16 (Curtis et al., 2019). Similar estimates have been reported for MSM living in other UK cities, such as Manchester (15.5%) (Schmidt et al., 2016). However, a review of the literature of chemsex and SDU among MSM in the UK found that prevalence estimates varied for both chemsex (17%-31%) and SDU (4%-41%), due to the method of recruitment and definition of the drugs used for each behaviour (Edmundson et al., 2018).

Whilst chemsex appears to be a relatively recent phenomenon, SDU among MSM and its associated sexual risk behaviours has been researched for some time (Halkitis, Parsons, & Stirratt, 2001; Mattison, Ross, Wolfson, Franklin, & HNRC Group, 2001; Stall & Purcell, 2000). A cross-sectional study into SDU among MSM found SDU, including other substances not associated with chemsex (e.g. amyl nitrates/poppers, cannabis), was associated with lower life satisfaction (Hibbert et al., 2019). Although engaging in chemsex (defined here as crystal methamphetamine, GHB/GBL, ketamine and mephedrone) was associated with a higher proportion of condomless anal intercourse than those engaging in other types of SDU, engaging in other types of SDU was still associated with a higher proportion of condomless anal intercourse than those who did not report SDU. Therefore, it is important not to neglect other substances that may also be associated with sexual risk. Although MSM engaging in chemsex tend to have a greater number of condomless anal intercourse partners, research has found that MSM engaging in chemsex are more likely to be taking pre-exposure prophylaxis (PrEP), thereby mitigating the risk of HIV acquisition (Hammoud et al., 2020; Hibbert, Brett, Porcellato, & Hope, 2020).

Chemsex research has tended to focus on sexual health outcomes, which is important to prevent onwards transmission of STIs and to understand any relationship between chemsex and blood borne viruses (BBVs), but research regarding potential psychological harms has been somewhat neglected. Motivations for engagement in chemsex have included the intense sexual experience, HIV stigma, and internalised homophobia (Weatherburn, Hickson, Reid, Torres-Rueda, & Bourne, 2017). Studies from the UK and Ireland have found that around 20% of MSM engaging in chemsex have reported chemsex was having a negative impact on their life (Glynn et al., 2018; Hibbert et al., 2019). Similarly, a study conducted in The Netherlands found that 23% of MSM wanted to receive counselling for chemsex related issues (Evers et al., 2020). It is important to note that only a proportion of those engaging in

chemsex report problems relating to their usage, and that those that experience problems are not representative of all MSM engaging in chemsex (Drysdale et al., 2020; Pienaar, Murphy, Race, & Lea, 2018; Race, 2017). However, help and support should be available for those who need it, and MSM have stated a preference for drug support within sexual health clinics (Bourne et al., 2014; Evers et al., 2020; Tomkins, Vivancos, Ward, & Kliner, 2018).

Currently, local government is primarily responsible for sexual health services in England which are paid for by a ring-fenced public health grant which is funded by the national government (Department of Health and Social Care, 2018). It has been suggested that sexual health clinics should adapt services for MSM engaging in SDU and chemsex in addition to promoting existing services (Frankis & Clutterbuck, 2017; Stuart, 2014; Tomkins et al., 2018). MSM in Ireland who indicated a desire and intention to cease engagement in chemsex stated the need for integrated drug and sexual health services to assist them to at least reduce and monitor their engagement as exit from the chemsex scene was a difficult process (Van Hout, Crowley, O'Dea, & Clarke, 2019). Whether sexual health services in the UK have adopted an integrated sexual health clinic varies across clinics depending on local need (Frankis & Clutterbuck, 2017; Stuart, 2014), but the reduced funding for UK sexual health services over the past decade may have negatively impacted any service development (BASHH/BHIVA, 2018). It has also been reported that the reduced funding has limited access to psychosexual service provision from sexual health clinics in the UK, as well as a reduction in the use of community organisations by sexual health clinics to provide additional psychosexual support (e.g. advice and peer support) (BASHH/BHIVA, 2018).

UK chemsex research has predominately focused on London (Stuart & Weymann, 2015), however, a higher prevalence of chemsex has also been observed in other regions of the UK (Edmundson et al., 2018), with broader SDU likely to be more common across the UK (Tomkins et al., 2018). Therefore, this research explored MSM and service provider (SP)

perspectives of service provision for MSM engaging in SDU and chemsex with a view to understanding current service provision and highlighting any needs for service development.

Methods

Qualitative semi-structured interviews were undertaken with MSM and service providers (SP) in Northern and Central England between January-December 2019. Ethical approval for semi-structured interviews with MSM was obtained from a University research ethics committee. MSM were recruited using a mailing list (n=210) from a previous cross-sectional online survey, although this sample was not exclusive to MSM who engaged in SDU and included LGBT people more generally (Hibbert et al., 2019), as well as from recruitment flyers at a community organisation that provided chemsex support. Participants had to be over the age of 18 years old, currently live in Northern or Central England and had taken one of 10 substances in the past 12 months immediately before or during sex (amphetamines, cocaine, crack cocaine, crystal methamphetamine, ecstasy, heroin, ketamine, GHB/GBL, mephedrone, poppers or other inhalants). Participants did not have to be engaging in sexual health services for support relating to SDU, as the aim of this research was to gain perspectives on their engagement with services generally. The interview schedule for MSM was informed by previous research regarding motivations and effects of SDU (Glynn et al., 2018; Hibbert et al., 2019), in addition to questions designed to assess engagement in sexual health services. Questions covered wellbeing and motivations in relation to SDU and experiences of engaging in SDU and sexual health services. Interviews were digitally recorded and conducted by one researcher at private offices, public locations with the required level of privacy, over the phone, or via Skype. Participants were offered a

£20 Amazon voucher for their time. Written informed consent was gained from MSM prior to each interview and the average length of interviews was 43 minutes (range 20-70).

Ethical approval for semi-structured telephone interviews with National Health Service (NHS) staff was obtained from the NHS Health Research Authority. A contact in the local NHS Trust suggested SPs for recruitment and emails were sent to these SPs. Sixteen SPs from five NHS trusts were recruited across four regions of Northern and Central England. An additional six were invited to interview but did not respond. Interviews were digitally recorded and conducted by three researchers as part of a larger research project that also examined service provision for PrEP (Hillis, Germain, Hibbert, Hope, & Van Hout, in press). Written informed consent was gained from SPs prior to each interview and the average length of interviews was 27 minutes (range 16-43).

Recruitment continued until data saturation was achieved. Two authors confirmed data saturation for MSM interviews and three authors confirmed data saturation for SP interviews as no new information was emerging. Interviews were transcribed verbatim and MSM and SP interviews were analysed separately using thematic analysis (Braun & Clarke, 2006). Initial codes were generated by two authors independently for six transcripts (3 MSM/SPs) to develop a coding framework for the remaining transcripts. Codes were organised into relevant themes, and themes were reviewed and refined by two authors. Typical quotes were identified to illustrate themes.

Results

Thirteen MSM took part in semi-structured interviews. Nine participants were recruited through the mailing list, and four participants were recruited through the community organisation. MSM participants had a median age of 34 years (range 23-66), with the

majority identifying as gay and White British (Table 1). Two participants were living with HIV and three participants were taking pre-exposure prophylaxis (PrEP). The majority of SPs recruited were genitourinary medicine (GUM) consultants (n=7, Table 1).

********Table 1 about here********

In this analysis, chemsex refers to the use of crystal methamphetamine, GHB/GBL, or mephedrone (no participants reported using ketamine). First, we discuss the positive and negative motivations MSM identified for engagement in SDU. We then discuss the provision of sexual health care for MSM engaging in SDU, identifying positives reported by both MSM and SPs. Following this are three themes related to barriers to care for MSM engaging in SDU: accessibility, funding, and SP's attitudes towards MSM who engage in SDU. Finally, experiences of services outside of sexual health clinics are discussed.

Motivations for engagement in SDU

The majority of MSM reported regularly engaging in SDU in the previous 12 months. All but one participant noted a sexual motivation for SDU and this was primarily to enhance the sexual experience. This was a key motivation regardless of the substance used. SDU was described as "intense", "euphoric" and "enhancing", with a number of participants noting how it creates an intense focus on sexual pleasure, creating a "little bubble" that was isolating in a positive way.

"That's the thing that I wanted, was to carry on using chems [GHB/GBL, mephedrone] and having sex, coz of the like how much of a more intense experience it was." – 31, Gay

"I think it [poppers] lends itself to a kind of subservient role, a kind of nothing else matters, it creates almost like a single focus, single focus in terms of like eroticism and sexual pleasure really." – 52, Gay

Some MSM also discussed positive psychological motivations for engagement such as increasing self-esteem. One participant outlined how chemsex helped them moderate their own drug use due to the confidence boost from chemsex, and therefore only took drugs when in that environment. This increase in self-esteem was related to feeling more attractive after being invited to more sex parties. This increase in social connections was also seen as a positive impact of chemsex by the participant.

For me it's been a really good thing [engaging in chemsex], like it's massively helped my confidence…Like I've made loads of friends at chemsex parties and stuff, like I dunno you just, I just feel like, you only mainly you only remember the bad stories you hear. It's just a fun thing, do you know what I mean? I dunno it's just, I really enjoy it. – 26, Gay

Three participants mentioned negative psychological motivations for engaging in sexualised drug use, such as loneliness and mental health. All of those who mentioned a negative psychological motivation had been engaging in chemsex and had stopped engaging, either because of the harm it was doing to them or due to having engaged in this behaviour for only a very small period of time. One participant reflected on how they were previously using drugs to *"self-destruct*" by engaging in a number of risk behaviours that could have had a

potentially negative effect on their health. Another participant described how the breakdown of a long-term relationship had left him "*grief-stricken*". This participant discussed how the use of chemsex drugs contributed to the worsening of his mental health; he was using the drugs to invite other men around for sex to ease the loneliness. One participant described how recently receiving a mental health diagnosis had led to a situation where they tried mephedrone, because they had stopped caring about life and their wellbeing.

Motivations [for chemsex]? Loneliness, I had been for seven years in what I considered a totally loving relationship and unfortunately my partner met someone else…I was grief-stricken, totally and utterly grief-stricken…. I used to say to everyone I haven't got anything to live for anymore, and that's that mental side that eventually I had to come to terms with and sort out, but taking the combinations of MKAT [mephedrone] and G [GHB/GBL] and then eventually doing a lot of Tina [crystal methamphetamine] did not help that mental state at all, it was trying to get someone round the whole time to fill the void – 66, Bisexual

Experiences of sexual health service provision

Most MSM were content with their engagement in SDU (n=9) and reported engaging in sexual health services primarily for routine sexual health screening. Other reasons for engagement in sexual health services included for HIV care (n=2) and to receive psychosocial support (n=2). MSM reported positive experiences generally, with some complimenting the staff for their friendliness, non-judgemental approach, and how informative the staff were, with one participant saying he found them *"really friendly…it's completely fine, very comfortable"* (29, Gay). Some MSM also noted how quick and easy the

service was to use and get referrals for further care relating to chemsex if needed. Another participant described his experience of using a specific chemsex clinic and how this helped him to manage his usage, as it was an opportunity to vent and receive reinforcement, which helped generate ideas of how to manage his chemsex behaviour.

It's not that I need it every week, but there's certain times where I just feel aw I'll give them a call, and just book in an appointment and just talk to them coz I think I need it at the moment, for both positive reinforcement and for possibly like advice really or kind of exchange of ideas...I mean, sitting there in that space with them, sometimes I come up with the realisation just by being there. – 41, Queer

Two SPs were positive about the services they are currently providing. One participant showed pride in running a specific service for MSM engaging in chemsex, stating *"I think we provide a really good service, actually, I'm really proud of it"* (SP13).

Barriers to care

Access to sexual health services

Seven MSM complained about accessibility of sexual health clinics generally, discussing the length of the waiting times and difficulty in getting an appointment, with one participant referring to them as *"sausage machines"* and stating *"They're overrun. The difficulty of getting an appointment"* (66, Bisexual). Six SPs identified accessibility as a possible barrier to care, identifying clinic opening times, a limited number of specific clinics for MSM, and a need to develop more accessible clinics for other patient groups such as

people living with learning impairments and trans people. One SP discussed whether the clinic was accessible around people's work life and suggested utilising online methods to reduce barriers regarding accessibility.

"Well not everyone conforms to the nine to five or the nine to seven screening…so if people could access things at a time that was convenient to them, so perhaps more online engagement, so we weren't trying to get people to fit in with what we already, when we're open" (SP11)

Funding

Lack of funding and current constraints on sexual health clinics were identified by some as significant barriers to service provision. Two MSM were aware of current funding constraints on sexual health clinics and attributed the barriers to care that they experienced to a lack of funding: *"I still don't think the government and that are taking sexual health serious. I think they think they put out this message 'use a condom' and that's enough and people just aren't"* (43, Gay). Another MSM referred to how austerity has impacted sexual health, and how the staff are doing the best they can with the resources they have.

"They're at a strain, austerity has hit them really hard and they're trying to run a complex service, dealing with a very sensitive issue, on a very limited budget, with very limited staff" - 41, Queer

Six SPs also identified funding issues as a barrier to providing optimum care for MSM engaging in SDU. This was seen to be a national problem, across sexual health generally, and whether funding for internal and external services would remain in place for current services for MSM engaging in chemsex was a concern.

"although whether that will remain as the budgets get cut further and further, who knows, because it's not a non-mandatory service and in many parts of the country, budgets for counselling and support have been slashed" (SP1)

SP's attitudes towards MSM who engage in SDU

Two MSM identified the attitudes of the SP as a barrier to care. One participant described an experience of receiving drug support, unrelated to SDU, from an HIV clinic. The participant reported how the SP's assumption that gay men who used drugs did so because of trauma related to their sexuality made him question his validity for help as he did not relate to this assumption from the SP, which then impacted his future help seeking behaviour.

"He was like really surprised that I was still in touch with my family and they were accepting of me being gay…like he was just really shocked that I needed help. So that made me feel like, do I actually need this help? Am I kind of valid for it or am I just being ridiculous? So

then when I get to a point that I know I need help, I'll just sit there for days and be like do I actually, or am I just being an idiot you know?" -26, Gay

Another MSM also rejected the narrative that people engaging in chemsex are doing so because of issues relating to their sexuality and how this is true for some experiences of chemsex but not all. This participant went on to discuss how they believe that this narrative is in fact counter-intuitive to providing help and support for MSM engaging in chemsex, because people who do not identify as having internalised homophobia but are in need of help may question their validity for help.

"This notion that chemsex is just gay tragedy on a par with the AIDS crisis, that it's this meaningless interaction inhabited by desperate people living at the edges of society, or fiercely addicted but unwilling to admit it because of this innate self-loathing, they're infantile, and they don't understand themselves so they have to deal with it by filling themselves full of meaningless sex and pumping drugs until they crash and it's just a nightmarish, ghoulish scenario. It's a description of an extreme end of chemsex and it's kind of like, and I'd say the majority of people who engage in chemsex for any length of time will experience some of that stuff, whereas it's not true of every experience of chemsex." – 41, Queer

Whilst some SPs stated that they had seen MSM patients who were engaging in chemsex because of issues regarding their sexuality, this was contextualised by SPs vocalising an open-minded attitude to MSM engaging in SDU, acknowledging variation exists among MSM who use drugs and conceptualising drug use as a spectrum. When discussing the variation among MSM engaging in SDU, one SP referred to an occasion where a woman had come seeking support for using GHB, providing further support to the need for

SPs to have an open-minded attitude to people engaging in SDU, so that optimum care can be provided.

"I think there is a whole complexity to drug use. That includes MSMs as well as people who aren't MSM…We have had a request for it [chemsex support] for non-MSM people recently, a young lady who had a real problem with GHB, which that service isn't commissioned to provide." (SP13)

Services outside sexual health clinics

Four MSM reported wanting further help and support for chemsex. Some MSM who engaged in chemsex reported negative experiences when seeking help and support for mental health and drug use from NHS services outside of sexual health clinics, such as from their general practice or from mental health services. Two participants were seeking help after attempting suicide, which they attributed to their engagement in chemsex. Participants described the lack of support available as being due to long waiting lists or referrals to services which no longer existed. This suggests both a lack of knowledge and services for MSM engaging in chemsex, as well as more generally for mental health support. Whilst participants successfully sought alternative help from community organisations, they faced barriers when attempting to access care in the NHS.

"When I tried to commit suicide the first time in 2015, there was nothing. There was absolutely nothing available. I wanted counselling at that time and there was an 18-month waiting period" - 66, Bisexual

"When I reported to my own GP and said actually, I've tried to kill myself because I'm a drug user, me GP gave me a telephone number for this team…that team had ceased existence five years ago" – 42, Gay

Long waiting lists were highlighted as an issue by SPs as well. One SP also pointed to long waiting lists for internal sexual assault referrals as well as referrals to external community organisations for male sexual assault and compared the length of both waiting lists, stating *"Our sexual assault referral centre has got a really long waiting list, longer than [community organisation's] so I'd always mention that for counselling"* (SP13). Another SP highlighted there was opportunity for service improvement concerning healthcare provision outside sexual health clinics, specifically due to a lack of knowledge from SPs outside sexual health. They described being contacted by external clinicians in some cases, but only when the patient was living with HIV, highlighting a greater awareness needed of SDU related issues outside sexual health settings.

"With things like inpatient admissions where people have overdosed…[it] hasn't always been ideal, and I think a lot of general physicians, the general hospital doctors, don't really know what to do. There are obviously guidelines in place now… and we're often involved, but only

if people are HIV positive…I don't know if they think to contact us if it's people that are just using chems, but they're not HIV positive." (SP14)

SPs discussed signposting MSM engaging in chemsex and other forms of SDU to external services, such as websites for information, or community organisations. SPs who mentioned referring participants to external services would highlight services available regardless of their need for support, to ensure they were informed.

"So I would ask specifically about chems, and if they disclose any risk at all, I would discuss [organisation] with them, I think it's, you know it's good for them to know about that service even if they don't want to engage with it. I think it's helpful that they know it exists and then they've got that choice really" (SP6)

Discussion

The themes identified in the study provide insight into the current state of service provision for MSM engaging in SDU in Northern and Central England. Most MSM had positive experiences of sexual health services generally, complimenting staff and the treatment they received. SPs appeared to have adopted a harm reduction approach to MSM engaging in SDU (Lenton & Single, 1998), highlighting available services to all of those engaging in this behaviour, thereby empowering them to make an informed choice if they ever needed support. A harm reduction approach for MSM engaging in chemsex has increased service uptake, community involvement, and is seen as a holistic healthcare approach (Bourne et al., 2014; Ma & Perera, 2016; Stardust, Kolstee, Joksic, Gray, & Hannan, 2018). Although SPs in this study were utilising a harm reduction approach, numerous barriers to care were identified, which were: access to sexual health services; funding; SPs attitudes towards MSM engaging in SDU; and access to services outside sexual health settings.

The most common complaint among MSM was access in terms of waiting and opening times. Accessibility as a barrier to care was noted by SPs as well. A solution suggested by a SP proposed utilising online methods as a possibility to reduce accessibility barriers, and research has found that MSM who have used HIV self-testing services reported it reduced barriers relating to convenience (Witzel et al., 2019). Therefore, more modern means of testing may help reduce this accessibility barrier, although further research is needed (Wellings, Mehl, & Free, 2017). Additionally, whether online methods could be utilised for MSM wanting further help and support in relation to SDU is unknown, and the utilisation of online methods for testing may reduce opportunities to signpost MSM engaging in SDU to further help and support.

Although the majority of MSM engaging in SDU were satisfied with the services provided by sexual health clinics and happy with their engagement in SDU, a number of MSM wanted further support. All MSM wanting further support relating to psychological impact of engagement in SDU were engaging in chemsex. Due to the small sample in this study, it cannot be said that those engaging in other types of SDU may be less likely to need further help and support beyond sexual health screening and further research is needed to investigate this. Both MSM and SPs highlighted potential barriers to care for MSM engaging in SDU wanting additional support for mental health and drug use. MSM have previously stated a preference for integrated drug services within sexual health clinics for chemsex support due to the non-judgemental attitude held by sexual health SPs (Bourne et al., 2014; Evers et al., 2020; Tomkins et al., 2018), and one participant who had engaged in this service had found it useful. This service user used the sexual health service as a means to monitor and reduce his engagement in chemsex when desired and previous research has found MSM expressing a desire for this type of service (Van Hout et al., 2019). However, SPs questioned whether funding for such services that were regarded as non-essential could be sustained considering the reduction in sexual health funding across the UK (BASHH/BHIVA, 2018). Both MSM and SPs noted funding constraints on sexual health services that may hinder any potential service development. It was interesting that some MSM were aware of issues regarding funding of sexual health services, suggesting that these funding constraints may be noticeable to service users (e.g. issues regarding access and waiting times), although awareness of funding constraints may have been gained through other sources (e.g. the media).

Both MSM and SPs noted some long waiting lists for services internal to sexual health clinics as well as community services (e.g. psychosexual support, sexual assault services), which is a barrier to care at a time when people may be particularly vulnerable.

Poor access to NHS mental health services has been reported across the UK (Care Quality Commission, 2019), therefore this finding is likely to be reflective of a lack of access generally, rather than being specific to MSM engaging in SDU. The lack of knowledge of chemsex and SDU outside of sexual health settings was raised as a barrier to care. Training for healthcare providers outside of sexual health may be needed to improve quality of overall care to MSM engaging in SDU.

Although MSM generally expressed satisfaction with service provision, one MSM reported negative experiences of seeking help for drug use unrelated to SDU at a sexual health clinic, where the SP's expectations that MSM with 'problematic' drug use must have experienced problems relating to their sexuality was off-putting. This was enough to make this participant question his validity for help in this instance, as well as possibly in the future. Congruent with previous research with MSM, the SPs in this study highlighted internalised homophobia as a possible motivation for engagement in chemsex for some MSM (Pollard, Nadarzynski, & Llewellyn, 2018; Weatherburn et al., 2017). However, they would often contextualise this statement by discussing the variability of chemsex, and how, in their experience, SDU encompasses a wide-ranging spectrum of behaviours. It is important to note that no MSM in this study identified internalised homophobia as a motivation for them to engage in SDU, and the main motivation identified by MSM as their reason for engagement was the sexual experience. Engaging in SDU usually involves multiple behaviours that may be stigmatised by society (Bourne et al., 2014; Pollard et al., 2018). It is possible that the stigma surrounding these behaviours, such as polygamy and non-monogamy (Frank, 2019; Moors, 2019), which are in themselves linked to same-sex sexual stigma for men (Herek, 2004), in addition to the stigma and marginalisation of people who use drugs (Room, 2005), all interact in the case of SDU resulting in the behaviour being highly stigmatised. Although the Minority Stress Model suggests internalised homophobia may be a factor in influencing

health behaviour among MSM (Meyer, 2003), it may not be as useful when discussing chemsex and SDU, as it can be off-putting to MSM who are experiencing problems relating to drug use but do not see their sexuality as a contributing factor.

Study findings also highlighted a potential problem of defining chemsex as a behaviour exclusive to MSM, as a SP recalled a heterosexual woman with problems related to GHB who could not access support services because these are specific to MSM. This highlights that even if chemsex is more prevalent among the MSM community, other groups may engage in this behaviour and will still need access to support services. Ensuring service providers understand that SDU and chemsex is a variable behaviour, with variable motivations for engagement, could avoid potentially stigmatising patients resulting in avoidance of future care.

One strength of the study was the inclusion of SPs, which added the perspective of front-line workers who interact regularly with MSM engaging in SDU, and therefore helped to contextualise some of the issues raised by MSM. A significant proportion of UK research regarding chemsex amongst MSM has been conducted in London (Bourne et al., 2014; Ottaway, Finnerty, Amlani, et al., 2017), so it is therefore a strength that this research explores the experience of chemsex in other parts of the UK, given the lack of generalisability in qualitative research. However, due to issues with MSM recruitment, it was not possible to completely match the geographical locations of service providers and MSM. A limitation of this research is that the inclusion criteria did not consist of an extensive list of substances that can be used for sexual purposes among MSM, such as cannabis (Parent, Ferlatte, Milloy, Fast, & Knight, 2020), and therefore these findings may not apply to all sexualised substances used. It also cannot be overlooked that the findings may reflect a self-selection bias. Both MSM who were currently engaging in SDU and MSM who had stopped engaging were recruited in an attempt to provide multiple narratives and experiences.

However, it is possible that those who wanted to voice their experiences were more likely to volunteer, but as with all qualitative research, the aim was to explore people's personal experiences of SDU and chemsex, rather than the representativeness of these viewpoints. Whilst not all barriers to care identified were specific to MSM engaging in SDU (such as funding and access), these are likely to impact on MSM engaging in SDU and chemsex, and are therefore still important and valid to highlight.

Conclusion

This study has highlighted that the majority of MSM who engage in SDU were satisfied with their sexual health care, but support services for those wanting further help are needed. There is a need to further develop service provision for SDU; however, continuation of current services is uncertain due to funding constraints, and increases in funding and training are needed to remove current barriers to care for MSM engaging in SDU. Services outside sexual health services such as mental health services have also received funding cuts, resulting in poor care for MSM engaging in SDU at a time they are particularly vulnerable, and funding to these services needs to increase if MSM engaging in SDU are to receive care when required.

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Table 1. Demographics of MSM and service provider participants.

	No. of participants	%
Men who have sex with men (N=13)		
Sexuality		
Gay	11	85%
Bisexual	1	8%
Queer	1	8%
Ethnicity		
White British	10	77%
White non-British	2	16%
Person of colour	1	8%
Work Status		
Full-time	10	77%
Student	3	23%
Relationship status		
In a relationship	6	46%
Single	7	54%
Location		
Lancashire	1	8%
Cheshire & Merseyside	2	16%
Greater Manchester	10	77%
Sexualised drugs used		
Cocaine	3	23%
Crystal methamphetamine	4	31%
GHB/GBL	4	31%
LSD	1	8%
Mephedrone	5	38%
Poppers	5	38%
Use of a chemsex drug (crystal methamphetamine, GHB/GBL, mephedrone)	5	38%
Service providers (N=16)		
Job role		
Consultant	7	44%
Speciality doctor	4	25%
Health advisor/psychotherapist	2	13%
Administrator	2	13%
Nurse practitioner	1	6%
Location		
Greater Manchester	4	25%
Cheshire & Merseyside	9	56%
West Midlands	2	13%
South Yorkshire	1	6%