

MAINLINE

TINA AND SLAMMING

MSM, CRYSTAL METH AND INTRAVENOUS DRUG USE IN A SEXUAL SETTING

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GLOSSARY

Ass play: anal insertion of fingers, fist, dildos or other objects

Barebacking: anal sex without a condom

BDSM: Bondage and Discipline, Dominance and Submission, Sadism and Masochism

- role play involving physical restraints, and focusing on intense stimulation and/or playing with power relations
- kinky sex

Booty-bumping: a mode of administering a water-soluble drug by injecting it into the rectum with a needleless syringe

Bottom: passive sexual role

Chems: drugs, chemical substances

Chemsex: having sex while under the influence of drugs/chemical substances

Coming out: self-disclosure of sexual orientation to the outside world

Coming down: immediate aftermath of drug use, during which the physical and psychological consequences of use are experienced

Crystal meth: methamphetamine (see: Tina)

Downer: narcotic drug (inhibitory effect on central nervous system)

Entactogen: a class of psychoactive drugs that produce experiences of emotional communion, oneness, relatedness and emotional openness

Fisting: sexual activity that involves inserting the hand (fist), and optionally a part of the arm, into the rectum

MSM: men who have sex with men

NPS: new psychoactive substances

Pig:

- aficionado of more extreme forms of sex
- sexually insatiable person

Rush: sudden and immediate surge of physical feeling experienced after taking certain drugs

Slamming: administering substances intravenously (into the veins)

Slang: terminology used within a group

Sleazy: uninhibited, relatively extreme sex, usually involving the exchange of bodily fluids

Tina (T): slang for crystal meth

Top: active sexual role

Upper: stimulant drug (stimulating effect on central nervous system)

Versatile: alternating sexual role

Viral load: amount of HIV (virus) per cubic millilitre of blood

Waus: to be under the influence of drugs

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In 2014 and 2015 Mainline conducted 27 in-depth interviews with Dutch MSM that have had some experience with crystal meth. Some of the men had also taken crystal meth or other drugs by intravenous means ('slamming'). Our sincere gratitude goes first and foremost to these men. The preparation of this report in collaboration with Soa Aids Netherlands would not have been possible without the trust granted us by these interviewees. Their candid stories, often of a highly sensitive and personal nature, offer a unique insight into their world. We hope that this insight will lead to a more complete understanding of chemsex and the consumption of crystal meth in the Netherlands. The initials of the forenames identifying the 27 men are fictitious. Their stated ages, however, are true.

Chapter 3 is a review of the existing publications on the use of crystal meth. We would like to thank Chantal Den Daas (RIVM) for critically examining this chapter. All available (recent) data regarding crystal meth use and the practice of slamming is presented in *Chapter 4*. We offer our deep gratitude to researcher Axel Schmidt (EMIS), who graciously made the unpublished analyses of the EMIS 2010 report available to us. This enriched our knowledge of the use of crystal meth in Amsterdam in 2010. Thanks also to researchers Ineke Stolte (GGD Amsterdam), Roeland Achterbergh (GGD Amsterdam), Astrid Newsum (AMC) and Fleur van Aar (RIVM) for providing recent data. We interviewed professionals for *Chapter 10* about their practical experiences with MSM that use crystal meth and about how healthcare professionals work in practice. Our profound gratitude goes to these professionals for taking the time to speak to us.

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1. CHEMS, CRYSTAL METH AND SLAMMING: AN INTRODUCTION



1. STATUS REPORT

A major European study conducted by EMIS in 2010 among MSM revealed that the Netherlands tops the list for substance use⁽¹⁾. The rate of substance use among MSM before or during sex is higher than in the general population⁽²⁻³⁾. The use of chemical substances during sex is called 'chemsex'. In the European Drug Report 2014, the European drug monitoring agency EMCDDA noted an increase in chemsex in Europe within some sub-groups of MSM. According to the EMCDDA, 'close monitoring of the issue is a public health priority'⁽⁴⁾.

This report describes two relatively new trends regarding chemsex in the Netherlands: the use of crystal meth (tina) and the practice of injecting drugs (slamming). 'Tina' and 'slamming' are slang terms, and are typically used within the MSM scene. Although up-to-date figures are lacking, it is believed that both the group of MSM that use crystal meth and those that slam are still relatively small. However, a plurality of signs indicates that it is a growing phenomenon.

This report describes the experiences of 27 men who have had some experience with crystal meth. Among them are 20 that have also had some experience with slamming. Firstly, this report provides an insight into a world that has remained largely hidden from view. The men's stories reveal the problems they face, where the knowledge gaps exist and what information and support these men need. It also describes how their contact with GPs and caregivers in the drug-treatment, HIV and STI support services often

end in disappointment. In addition to issues relating to treatment, MSM that use crystal meth encountered a lack of knowledge of crystal meth, chemsex and slamming among the various professional groups. This status report aims to contribute towards raising the level of knowledge among professionals about this group and their lifestyle. The report outlines the context of chemsex, crystal meth use and slamming, and makes recommendations for the development of adequate prevention and care services.

1.2 BACKGROUND TO THE REPORT

Mainline and Soa Aids Netherlands do not aim to problematise chemsex. MSM that use substances in conjunction with sex typically do so to enhance their enjoyment of sex, and this personal choice is not necessarily a problem in itself. However this report, and other research, shows that there is more than one reason why chemsex has the potential to become problematic. This risk exists primarily where chemsex involves particular substances and routes of administration, such as crystal meth and slamming. Crystal meth is a very powerful drug, which due to its euphoric effect and its ability to increase sensory perception is often used in conjunction with sex. Frequent use of crystal meth can in due course pose serious risks to physical, sexual and mental health. These include risks arising from reckless or incorrect use due to a lack of information, or risks arising from use in combination with other substances. The slamming route of administration may also pose additional risks. Furthermore, there is a risk

of developing physical and psychological problems due to overuse as well as the risk of becoming drug dependent.

Another health problem lies in the potential transmission of HIV and other STIs while under the influence of drugs. Due to the strong disinhibiting effect of drugs, intentions to practice safe sex or to take risk-reduction precautions can be overruled by the impulse to engage in sexually risky behaviour. Numerous studies have established a relationship between chemsex and sexually risky behaviour, and revealed that STIs such as HIV and hepatitis C tend to occur at higher rates in sexual networks where drugs are used.

In recent years, Mainline and Soa Aids Netherlands have been alerted with increasing frequency by MSM about the growing use of crystal meth in their milieu. The stories that trickled in about the suicides of crystal meth users testified to the serious impact the drug can have on mental health. Although these men also struggled with other issues, the stories suggest that the frequent use of crystal meth played a significant role in their downward spiral. In addition, medics working in HIV- and STI-care services occasionally turned to Mainline and Soa Aids Netherlands for answers in dealing with men who use crystal meth.

Crystal meth use has been observed for years in Southeast Asia, the United States and Australia, both amongst MSM and in the general population. For a long time in Europe, methamphetamine was only available in Eastern Europe. But data collected by EMCDDA shows that in recent years, methamphetamine laboratories have also been raided in Belgium and the Netherlands. This may indicate a growing demand for the product in North-western Europe. Neighbouring Germany has reported a twenty-fold increase in the amount of methamphetamine intercepted in the past few years. In Norway and Sweden, crystal meth is often sold as ordinary amphetamine, and there's been a sharp increase in both countries in the number of people reporting to drug-treatment clinics with methamphetamine addiction. In Southern Europe (Greece), there's been a sharp increase in the use of crystal meth among opiate users in particular. There methamphetamine is known as 'shisha'. The indications from big cities like London and Paris are that in some subgroups of MSM, the primary mode of use is slamming. A large study carried out in London (the Chemsex Study 2014) revealed that drugs are often used during sex, crystal meth in particular⁽⁵⁾.

The high rate of mobility of Dutch men in the international MSM scene could be an important accelerating factor in the rise of crystal meth. European research EMIS⁽¹⁾ shows that in 2010, on average, Dutch MSM visited a foreign city more often than MSM from other European countries. The average number of European trips by Dutch MSM was 2.5 per year. The purpose of these visits was to attend annual Gay Pride events, visit clubs and dance parties, and attend chemsex parties. Besides London and Paris, the most frequently visited cities were the 'gay capitals': Berlin, Barcelona and Madrid. The use of crystal meth in chemsex

is relatively high in these cities.

From fieldwork carried out between 2012 and 2015 on dating sites and apps for MSM, Mainline found that crystal meth was becoming increasingly popular among this group. References to this substance appeared with increasing frequency in people's profiles. MSM were giving direct or indirect indications that they were seeking sex involving crystal meth. By and large, this group rarely uses the term 'crystal meth'. Rather, they'll typically refer to 'tina', or simply 'T', or use an uppercase 'T' in words that include a 't'. At the same time, there were MSM that indicated their explicit opposition to having sex with men who used crystal meth during sex. Men were rarely explicit in their profiles about wanting to slam on a sex date. Those who were explicit about wanting this often indicated their desire by stating that they wanted to come 'to the point'. This online research by Mainline also revealed that with the growing popularity of crystal meth use among certain groups of MSM, the number of online dealers was rising. The supply of crystal meth was initially limited to a small number of dealers operating for the most part within the Randstad. In the last year of the fieldwork, Mainline found that more than half of the online dealers were now offering crystal meth, in addition to ecstasy, GHB, mephedrone, ketamine and cocaine. The increase in both the demand for crystal meth and the number of dealers offering the drug has led to a drop in price. Crystal meth is still an expensive drug, but the falling price has probably lowered the barrier to using it.

In the course of 2013, Mainline's fieldworkers saw growing signs of a high level of drug use among male sex workers. This led to a collaboration with P&G292 (GGD Amsterdam's prostitution and health centre) to begin investigating drug use during sex work by male and transgender sex workers. The aim of the study was to gain more insight into the nature and function of substance use during sex work, and to find out whether a relationship exists between substance use and sexually risky behaviour. Some respondents admitted to using crystal meth. They claimed they were able to earn more when using the drug because it enabled them to go on for longer and made it easier to engage in more extreme sex practices. Some indicated that sex work under the influence of crystal meth often didn't involve condoms, and that the drug was often injected in an unsafe manner⁽⁵⁾.

The persistent indications of the growing use of crystal meth by MSM were grounds for Mainline to research the issue further in 2014. MSM that had had some experience with crystal meth were recruited to participate in semi-structured interviews. These interviews were initially exploratory in nature. The aim was to gain more insight into both the nature and the extent of use. It became clear from these exploratory interviews that chemsex under the influence of crystal meth was not limited to a few individuals or a single network. Thus Mainline decided to interview more MSM that use crystal meth. The interviews also revealed that there were MSM that rarely or never used crystal meth, but did slam other drugs.

It became clear in the course of 2014 that many of the respondents had a considerable need for information about crystal meth and its use. The need for assistance regarding dependence on the drug was also considerable. On the subject of STIs, the primary need was for information on the prevention of the transmission of hepatitis C. (See *Chapters 6 and 9*.) One-third of respondents had hepatitis C or had had this infection. All the men who reported this were HIV-positive. No one appeared to have questions about HIV. For instance, none of the respondents needed information about adherence to HIV treatment. However, a minority of HIV-positive respondents said their viral load was not always undetectable, but fluctuated slightly. A detectable viral load increases the risk of HIV transmission.

Mainline discussed its findings with Soa Aids Netherlands. These organisations then decided to put together a joint status report on the subject, the result of which is before you. The findings from Mainline's fieldwork are supplemented by research among professionals in the field of drug-treatment, mental health, HIV and STI care. The interviews with these professionals were held in the spring of 2015. The results of these interviews are covered in *Chapter 10*. In addition, we conducted a review of the existing publications (*chapter 3*) and mined data obtained in the Netherlands regarding the use of crystal meth and the slamming of drugs (*Chapter 4*). Conclusions and recommendations formulated on the basis of this report are set out in *Chapter 11*.

In this abbreviated English version of the report, the focus is on the fieldwork data and crystal meth. The background information from existing publications, the quantitative data about the Dutch situation and the data from the interviews with the professionals are not included in this English translation. *Chapters 4 and 10* consist summaries only.

Objectives of this report

- provide insight into crystal meth and intravenous drug use during sex by MSM
- shed light on the reasons why MSM choose chemsex in general, and use crystal meth and the slamming mode in particular
- shed light on the risks posed to MSM by their engagement in chemsex and/or the risks they are willing to take
- describe any information and support needs of MSM that use crystal meth and/or engage in slamming
- offer recommendations regarding the improvement of both the monitoring of crystal meth use, slamming and sexually risky behaviour in chemsex, and the current range of information and support services available to this target group

1.3 DEFINITIONS

CHEMS AND CHEMSEX

Chems (short for chemicals) is MSM slang for drugs. For the purpose of this report, 'chemsex' stands for use of drugs in conjunction with sex. This deviates from the definition of the term as understood in the United States and the United Kingdom. In the United States, chemsex is commonly taken to mean 'sex under the influence of crystal meth, GHB/GBL or mephedrone'. In the United Kingdom, chemsex is also used to describe sex under the influence of ketamine and cocaine. Mainline and Soa Aids Netherlands are of the opinion that the specific hard drugs used are of minor importance, as are the routes used to administer a drug. What's important is which drugs MSM themselves associate with chemsex. This report therefore uses the broadest definition of the term chemsex: all drugs used in conjunction with sex, with the exception of alcohol, cannabis and poppers. As such, this report relates specifically to the way MSM communicate about the practice of using drugs in conjunction with sex. Dutch MSM rarely use the term 'chemsex'. They mostly speak of 'chems' or say they're 'chem-friendly'. What they're referring to when they say this is not so much the use of drugs in nightlife social settings, as substance use in conjunction with sex in a private setting.

DESIGNER DRUGS

Substances developed in laboratories with the specific purpose of creating mind-altering effects are called 'designer drugs'. The way these substances work is often similar to that of the more readily accessible drugs, such as ecstasy, speed and cocaine. Because these substances consist of new chemical compositions, they are not initially illegal when they appear on the market. They are also called 'legal highs', 'new psychoactive substances' (NPS) or 'research chemicals'. Dozens of new designer drugs appear on the market every year, mostly via the internet. At the moment, some sexual networks within the chemsex scene are experimenting a lot with the drugs 4-MEC, 3-MMC, methoxetamine (MXE) and 4-FA. If these drugs prove to enhance sexual experience, then their fame and popularity will rise rapidly.

COMBINATION USE

The simultaneous use of multiple substances is called 'combination use' or 'poly-drug use'. A wide range of drugs are used during chemsex parties: ecstasy, MDMA, GHB, GBL, cocaine, speed, 4-MEC, mephedrone, 3-MMC, MXE, 4-FA and crystal meth. These drugs are often used in combination with Viagra, Kamagra or other erectile-dysfunction drugs. In this manner, the adverse effects of one drug are offset by the beneficial effects of a second or third drug. Sometimes the purpose of combination use is to eliminate the effects of another drug. The combination of different drugs can also yield a completely new effect. Not all substances are suitable for use in combination with

1 Overview of substances used by Dutch MSM during chemsex

Name	Street name	Background information	Effect	Routes of administration
3-MMC	3-MMC	Closely related to mephedrone, but possibly less potent and therefore of less interest to users. According to some users, it generates lower feelings of euphoria and has a shorter-lasting effect than 4-MEC or mephedrone, and coming down off it is less debilitating. New on the market, and little is known about it.	Energising, entactogen-like effects, euphoric	Nasal, rectal, intravenous
4-MEC	4-MEC, NRG	Derivative of cathinone (the active ingredient in khat). There is hardly any information available to users. Often slammed at short intervals to maintain and/or enhance the euphoric effect.	Energising, entactogen-like effects, euphoric	Oral, nasal, rectal, intravenous
4-Fluoroamphetamine (4-FA)	4-Fluoro, 4-FMP, 4, 4-flava, 4-F	Amphetamine-derived substance whose effects lie somewhere between those of ecstasy and speed. Has become relatively popular in a short space of time, including within the party scene. Appears to be here to stay.	Energising, entactogen-like effects, euphoric	Oral, nasal, rectal, intravenous
Cocaine	Coke, Charlie, Blow, Snow, White	Stimulant with a long history and a relatively short-lived effect. Local anaesthetic. Active ingredient derived from the South American coca plant. The smokable variant is called crack, crack cocaine or base coke.	Energising, euphoric	Nasal, smoking, rectal, intravenous
Crystal meth (methamphetamine)	Meth, Crystal, T, Tina, Ice, Yaba, Shabu, Shisha	Amphetamine-like stimulant, generates euphoria and its effect lasts longer than speed. Used by soldiers during WWII. Popular in "gay capitals" all over the world, and on the rise within the Dutch chemsex scene.	Energising, aphrodisiac, euphoric	Nasal, oral, rectal, smoking, intravenous
Ketamine	Keta, Ket, K, Special K, Vitamin K	Dissociative anaesthetic. Used as medication. Ketamine available on the black market often comes from India or China. Popular in the gay scene for over ten years. Regular use creates a high probability of heavy psychological dependence.	Dissociative, aphrodisiac, psychedelic	Nasal, intravenous, intramuscular, rectal
GHB/GBL	G, Liquid ecstasy, Auntie G	Endogenous substance. Used to treat narcolepsy. Difficult to gauge correct dosage. Use can easily result in short-term coma or in more extreme cases death.	Sedative, euphoria, aphrodisiac, entactogen-like effects	Oral, rectal, intravenous (rare)
Mephedrone (4-MMC)	M-Cat, Drone, Meow meow, Miaow, Plant food	Cathinone-derivative. Achieved rapid popularity (especially in England); appears to be on its way out. Use tends to compel redosing. Its effect, for some, is similar to that of cocaine.	Energising, euphoric, entactogen-like effects, aphrodisiac	Nasal, oral, anal, intravenous
Methoxetamine (MXE)	MXE, Mexxy, Roflocptr	Very powerful drug, similar to ketamine. Long-lasting effect. After-effects (drowsiness, vagueness) noticeable for up to 24 hours. Of little effect when taken orally.	Dissociative, psychedelic, aphrodisiac	Sublingual/buccal ('under tongue'- orally limited effect), nasal, rectal, intramuscular, intravenous
Ecstasy / MDMA	M, MDMA, Molly, X, Sweet, Pill, Candy	Used recreationally since the 80s. The most popular party drug for years. Ecstasy pills are cheap in the Netherlands, and fairly pure. Most problems come about as a result of high-dosage pills rather than on account of contamination (with PMMA, PMA and mCPP)	Entactogen-like effects, euphoric, aphrodisiac	Oral, nasal (sometimes), intravenous (rare)

other drugs. The combination with new designer drugs entails additional risks: little or nothing is usually known about new chemical compositions and their interaction with other drugs.

CRYSTAL METH

The chemical methamphetamine, better known as crystal meth, is an enhanced form of amphetamine (speed). It is mainly available on the Dutch market in the form of white, glassy crystals. The drug can be snorted, swallowed, smoked or injected (slammed). Crystal meth is an 'upper', and thus belongs to the same group as cocaine and speed. Uppers stimulate the sympathetic nervous system: they act like an accelerator. These substances make the user more alert and energetic, and raise the heart rate and blood pressure. Among MSM, crystal meth is mostly known as 'tina'. Outside the MSM scene, it is called T, meth, ice, glass, crystal, yaba, shabu and shisha. The effect of crystal meth lasts for five to eight hours, much longer than that of speed. The duration and intensity of effect is determined by the dose, route of administration and by any developed tolerance to the drug. Crystal meth has a considerable sexually stimulating effect, making it more likely that its users overstep their sexual boundaries. Its effects include: intense euphoria, reduced response to pain stimuli, increased alertness, and a long-lasting 'energy boost'. Users feel confident and lose all sexual inhibition. Sex sessions can go on for days under the influence of crystal meth. The drug offers a much more intense experience than other substances. The hangover from taking crystal meth is called 'coming down'. This dip can be very severe, and recovery often takes days. During and after coming down, many users experience a strong desire to take the drug again ('craving').

SLAMMING

MSM call the intravenous administration of drugs 'slamming'. Slamming often involves crystal meth, although mephedrone, ketamine and most designer drugs can also be injected directly into the bloodstream. Slamming is a metaphor. The term refers to the loud slamming of a door and is based on the immediate, overwhelming effect of injecting a drug. On account of this effect, slamming is seen as the most extreme mode of administering a drug. The first rush begins almost immediately after slamming and lasts for five to ten minutes. The use of needles carries additional health risks, such as vascular injury, abscesses, and a higher chance of overdosing. When needles are shared with other users, there is also the risk of transmitting infections, such as HIV and hepatitis C. Slamming appears to increase the likelihood of developing a drug dependency, and of experiencing adverse effects on physical and mental health.

Slamming is the commonly used term for the intravenous administration of drugs. Occasionally, the term is also used within the slamming scene to refer to other modes of administering a drug:

- muscling (injection into the muscle)
- skin popping (injection under the skin)
- booty bumping (rectal insertion through a syringe without a needle)

In this report, 'slamming' is used to refer to the intravenous administration of drugs. In instances of other routes of administration, we employ the relevant commonly used name.

1.4 STRUCTURE OF THE REPORT

This report is structured thus:

- methodology and characteristics of the research population (*Chapter 2*)
- review of existing publications: information about crystal meth only, for the abbreviated English translation: section 3.1 (*Chapter 3*)
- summary of data obtained in the Netherlands regarding chemsex, crystal meth use and slamming (*Chapter 4*)
- qualitative research findings from interviews with MSM that have some experience with crystal meth use and/or slamming (*Chapters 5, 6, 7, 8 and 9*)
- summary of interviews with professionals from various professional groups who come into contact with MSM (*Chapter 10*)
- conclusions and recommendations (*Chapter 11*)

Each chapter concludes with a summary of the main points.

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2. METHODOLOGY



This report was composed from various sources. It includes a review of existing publications (*Chapter 3*) and an analysis of the data obtained in the Netherlands regarding chemsex, crystal meth use and slamming (*Chapter 4*). Qualitative data was collected on the basis of 27 interviews with MSM that use crystal meth and/or practice slamming (*Chapters 5 to 9*). Additional qualitative data was collected via interviews with professionals from the healthcare sector (*Chapter 10*).

2.1 REVIEW OF PUBLICATIONS

The review of existing publications sought information on:

- short- and long-term effects of crystal meth use
- the risks associated with crystal meth use
- determinants of chemsex, crystal meth use and slamming
- determinants of the loss and maintenance of control
- risks of blood-borne viruses due to injecting and snorting
- links between drug use and sexually risky behaviour, with a particular focus on crystal meth and slamming
- the impact of crystal meth on adherence to HIV treatment
- the interaction of crystal meth and HIV inhibitors
- the syndemic theory as a framework for the prevention of drug problems

We found a total of 110 relevant articles. In this abbreviated English translation, we have only included the information about crystal meth in *Section 3.1*, and a summary of mined data in *Chapter 4*. We have, however, included the complete list of references from the Dutch version.

2.2 DATA OBTAINED IN THE NETHERLANDS

For the purpose of this report, we sought figures on chemsex, crystal meth and slamming in the Netherlands. First, we analysed national behavioural studies conducted among a broad population of MSM. The last MSM-wide study was 'A World of Difference' by Rutgers (2013). Before that there was the Schorer Monitor (2011), and before that the great European MSM survey, EMIS (2010). The studies give some idea of chemsex in the period between 2010 and 2013 and are therefore discussed in this report. However, none of these studies included information about the national use of crystal meth or slamming in recent years. We therefore had to look further:

- We contacted EMIS's research division, which will soon be publishing a report on drug use in 44 European cities. The lead researcher was willing to let us have the figures for Amsterdam. Note that this information is a secondary analysis of the 'old' EMIS study, and thus concerns data from 2010.
- More recent data was obtained from GGD Amsterdam's Amsterdam Cohort Studies (ACS), also known as the 'Gay cohort'. Participants in this cohort are surveyed every six months with questions about their general and sex-related drug use.
- Data was also obtained from the MS2 project, another cohort assembled by GGD Amsterdam. This cohort is made up of MSM with a high risk of HIV and other STIs. Members fill in a questionnaire every three months, and some of the questions are about drug use. There is a high incidence of drug use in this cohort: 70 per cent

of the participants use drugs; 90 per cent of them in conjunction with sex.

- We contacted the MOSAIC study, the hepatitis C study running in several Dutch hospitals, in which HIV-positive MSM with and without hepatitis C participate. Members of this cohort also provide regular information about their drug use during sex, as well as their route of administration. An important reason for requesting data from the MOSAIC study was that the first analysis of the interviews revealed that a significant number of the men had (or had had) hepatitis C.
- Data was obtained from RIVM on intravenous drug use among visitors to STI clinics (another very specific group of MSM). Until 2014, every STI clinic in the country was mandated by RIVM to keep a record of visitors who used drugs by intravenous means.

2.3 INTERVIEWS WITH MSM THAT USE CRYSTAL METH AND-OR ENGAGE IN SLAMMING

RECRUITMENT

The recruitment and interviews (which took place between January 2014 and May 2015) were conducted by one of the authors of this report. Most interviews were conducted face-to-face⁽²¹⁾, five were conducted online and one respondent was interviewed by phone.

1 Recruitment of respondents

Via	Number
Fieldwork	5
Contacts within the target group	3
STI medics, HIV counsellors and addiction specialists	6
Previously interviewed respondents	4
Dating sites and online chat rooms	9
Total	27

The only inclusion criterion was for respondents to have had some experience with crystal meth. While interviewing, it became clear that there were MSM that administered drugs by slamming, but seldom or never used crystal meth. We decided to interview one respondent who injected drugs other than crystal meth, because it relates to the theme of the study and because it offers some insight into this hitherto rarely encountered form of administration of substances by MSM.

We sought a geographical spread when recruiting. However, this was only partially successful as it was difficult to find respondents outside the Randstad. The respondents were not pre-selected according to age, location, frequency of use, HIV and hepatitis C status, sexual choices and extent of sexually risky behaviour. Consequently, this sample should not be taken as representative.

The questionnaire was extensive and covered various topics. The interviews were semi-structured: not all questions were asked of all respondents, as the questions asked in each interview depended on answers to the previous questions and the circumstances of the respondent. For instance, we did not enquire about the social background of the online respondents, nor did we probe as deep on such topics as barebacking, HIV and hepatitis C. However, all respondents were asked for their demographic details, about their substance use and its relation with sex, and about their information or support needs.

TOPICS

The topics discussed in the in-depth interviews with MSM, centred around:

- personal-use history and how the men came into contact with crystal meth and/or slamming
- how often, in which settings, and why they use chemical substances
- routes of administration
- their favourable and unfavourable experiences with crystal meth
- where they obtain their paraphernalia (syringes and other props)
- whether sexually risky behaviour takes place during chemsex
- their support or information needs regarding crystal meth use and sexual health

When a respondent's replies suggested a level of substance use beyond recreational, the respondent was asked about their experience with the support services, and notes were taken on any gaps in the services currently on offer.

DEMOGRAPHICS

Place of residence and origin

The respondents' place of residence are concealed and categorised by province. The majority were resident in the Randstad, mostly in North Holland (17). Four respondents were born and raised abroad: Southern Europe (2), Eastern Europe (1) and Asia (1).

2 Respondents' province of residence

Province	Number
North Holland	17
South Holland	2
Utrecht	2
Overijssel	1
Gelderland	2
North Brabant	2
Limburg	1
Total	27

4 Coming out

Age on coming out	Number
< - 15	2
16 - 20	9
21 - 25	6
26 - 30	2
31 - 35	-
36 - 40	1
41 - 45	2
46 - 50	1
51 - >	-
Unknown	4
Total	27

Age

The youngest respondent was 23 years old, and the oldest 60. The average age was 42.8; median 43.

3 Age of respondents

Age	Number
< - 20	-
21 - 25	1
26 - 30	5
31 - 35	2
36 - 40	3
41 - 45	6
46 - 50	3
51 - 55	4
56 - 60	3
60 - >	-
Total	27

Work and Income

Fifteen of the respondents were in paid employment, nine were unemployed and three were on incapacity benefits (due to burnout, depression or while undergoing treatment for drug dependency). Three respondents had engaged in sex work.

Coming out

All respondents identified as homosexual. More than three-quarters of the men came out before the age of 25. Two respondents came out in their early teens (14 and 15), while three came out in their 40s after years of being married to women. Coming out was a difficult experience for twelve respondents, and involved rejection by family and/or friends. The age and experience of coming out is unknown in the case of four respondents.

Age on first occasion of substance use

The age at which respondents experimented with drugs for the first time varied. One respondent's first experience with drugs was not sex related. One-third of the respondents were over thirty when they first used drugs.

5 Age on first occasion of substance use

Age	Number
< - 20	5
21 - 25	5
26 - 30	7
31 - 35	1
36 - 40	2
41 - 45	4
46 - 50	1
51 - >	1
Unknown	1
Total	27

Relationships

Twelve men were in committed relationships at the time of the interviews, with ten of them living with their partner. There were two couples in the group of interviewees. Almost all of the men also had chemsex with their regular partner. One respondent's partner never used drugs. Fifteen men were single.

2.4 INTERVIEWS WITH PROFESSIONALS

Exploratory research was conducted among professionals in the drug-treatment services, mental health care services, crisis centres and GP practices, and among HIV care providers. Only two interviews were held with professionals in the field of STI. The main reason for this was that the interviews had to be completed within a limited time frame. We therefore assumed (perhaps wrongly) that due to the limited time allotted per STI consultation, the subject of drug use probably does not typically arise.

The interviews with professionals took place on the basis of a pre-prepared questionnaire, and the following topics were discussed:

- whether and how crystal meth use comes to the attention of the paramedics, Accident and Emergency services (A&E), and the Drugs Incident Monitor (MDI)
- whether HIV and STI medics and other healthcare professionals (e.g. GPs) whose clients include MSM:
 - enquire about substance use and chemsex
 - notice signs of mental health problems among MSM that inject crystal meth and/or drugs, and their experiences with referring clients to other healthcare providers
 - notice signs of sexual health problems among MSM that inject crystal meth and/or drugs.
 - (with specific reference to HIV-positive MSM undergoing antiretroviral therapy) whether the professionals see any indications that using crystal meth affects the clients' adherence to their therapy
- their experience of working with the drug-treatment services
- whether healthcare professionals working in the drug-treatment services:
 - come into contact with MSM that use drugs in a sexual setting, and more specifically with MSM that use crystal meth and/or take drugs intravenously
 - enquire about the relationship between substance use and sex, and whether and how this is recorded
 - notice signs of mental health problems among MSM that have chemsex, and more specifically among MSM that use crystal meth and/or take drugs intravenously
 - take action when they notice mental health problems
 - have an 'MSM-sensitive' chemsex-treatment programme to offer when they discern a need for it

3. REVIEW OF PUBLICATIONS



A lot has been written about crystal meth over the past 30 years. The bulk of the available research on the subject comes from the US, where the popularity of crystal meth began to rise in the early 90s. Other publications are mainly from Australia^(25,60,79) and the UK^(22,24,63-64). As a result, a lot is already known about the short- and long-term effects of crystal meth use and the related health risks (Section 3.1). Scientists have also studied the motives and psychosocial factors associated with chemsex in general, and crystal meth use and slamming in particular. They've also examined factors that potentially play a role in the loss or maintenance of control (section 3.2). To a great extent, most of the existing publications are about the relationship between the use of crystal meth and sexually risky behaviour. Researchers have also studied the influence of crystal meth on the adherence to treatment of MSM being treated for HIV (section 3.3). A discussion of the syndemie theory appears towards the end of this review of publications, as this theory may provide a point of reference for future interventions on the relationship between psychosocial factors and drug-related problems. Only section 3.1 is included in the abbreviated English translation. However, the complete list of references from the original Dutch version has been included here.

3.1 CRYSTAL METH: SHORT- AND LONG-TERM EFFECTS AND HEALTH RISKS

Crystal meth, the street name for methamphetamine, is chemically related to amphetamine (speed) and belongs

to the sympathomimetic amines. These are compounds that mimic the neurotransmitters (such as adrenaline, noradrenaline and dopamine) of the sympathetic nervous system. Methamphetamine is, by the addition of a methyl group, many times stronger than amphetamine. This addition renders it much more soluble in fats, so that it is able to penetrate the blood-brain barrier and thus act directly on the brain. Crystal meth is neurotoxic (toxic to the nervous system), and can both damage the neurotransmitter receptors and alter the structure and operation of the blood-brain barrier⁽¹⁻²⁾.

Many of the effects, but also the risks and consequences, are directly traceable to the stimulation of the sympathetic nervous system (similar to a stress reaction) and the alteration of the 'normal functioning' of the release, transmission and uptake of the neurotransmitters, compounds that enable communication between nerve cells. Several studies have revealed evidence of reduced dopamine levels following repeated use of crystal meth⁽³⁻⁴⁾. In studies of both humans and animals, the alterations were observed within a few days of exposure to crystal meth and, depending on the intensity and duration of use, remained detectable for months to years afterwards⁽³⁻⁵⁻⁶⁾. Visible changes were also observed in the serotonin system, which partly explains the dip experienced after using crystal meth⁽⁷⁾.

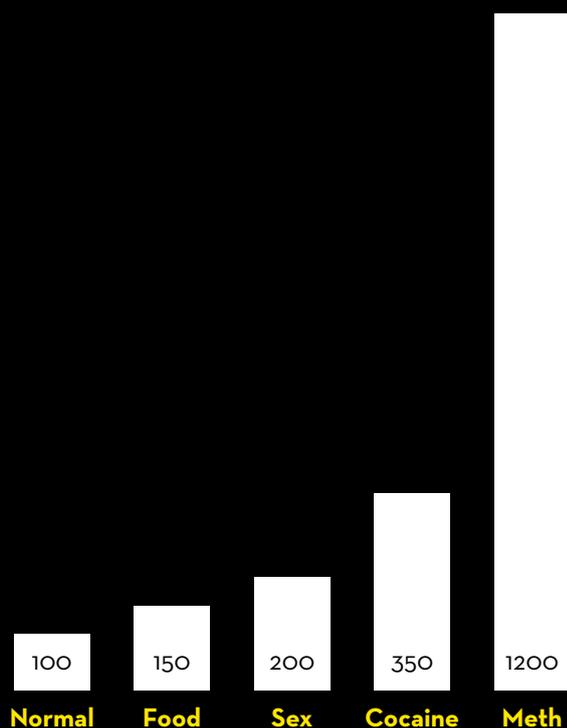
Crystal meth is known to have the strongest effect of any drug on the dopamine system. Dopamine is a compound involved in many of the body's processes. Its most

important function is to be a neurotransmitter. Roughly speaking, dopamine caters to three communication paths in the brain. It affects the control of movement, cognition and planning, particularly goal-oriented action, and has a huge influence on the regulation of emotions and motivation.

Dr. Richard Rawson, a professor at UCLA's Brain Research Institute, describes the effect of crystal meth on the dopamine system as follows:

"Meth users have described this feeling as a sudden rush of pleasure lasting for several minutes, followed by a euphoric high that lasts between 6 and 12 hours, and it is the result of the drug causing the brain to release excessive amounts of the chemical dopamine, a neurotransmitter that controls pleasure. All drugs cause the release of dopamine, even alcohol and nicotine, but crystal meth produces the mother of all dopamine releases. In lab experiments done on animals, sex causes dopamine levels to jump from 100 to 200 units, and cocaine causes them to spike to 350 units. Methamphetamine releases about 1,200 units, so much more of a release of dopamine than you get from food and sex and other pleasurable activities. This kind of increase really doesn't occur from any normally rewarding activity. That's one of the reasons why people, when they take methamphetamine, report having this euphoric feeling that's unlike anything they've ever experienced. Then, when the drug wears off, users experience profound depression and feel the need to keep taking the drug to avoid the crash."

1. The amount of dopamine released in response to food, sex, cocaine and crystal meth



THE IMMEDIATE EFFECT OF TAKING CRYSTAL METH

The immediate effects of taking crystal meth are often similar to those of other amphetamines, albeit in greater intensity and for longer duration, and sexual arousal is much more pronounced. Crystal meth is, as mentioned, often used because it stimulates a boost in energy and alertness, generates euphoria and enhances sexual sensation. In addition, crystal meth has a number of side effects, some of which may cause problems even when the drug is used only once, and/or in the event of an overdose.

- raised blood pressure and heart rate
- raised body temperature
- loss of appetite
- diminished need for sleep
- clenched jaw muscles and gnashing of teeth
- extreme dryness in the mouth
- nausea, vomiting and diarrhoea
- erection problems
- anxiety, irritability and aggression
- uncontrollable twitching in the face and limbs
- inflated sense of self-confidence and strength

LONG-TERM EFFECTS AND RISKS OF CHRONIC CRYSTAL METH USE

Prolonged use of crystal meth may pose health risks. However, scientific substantiation of a direct link between long-term substance use and the onset of symptoms or illness is generally difficult to establish due to a variety of difficult-to-control factors affecting the life of a user. The immediate effects of use are easier to demonstrate than the long-term effects.

Furthermore, laboratory experiments with animals involving the use of pure substances create a totally different reality to that of the real world of the user. Thus, a meth user will often use a combination of drugs (poly drug use) rather than just crystal meth. In addition, illegal drugs are usually adulterated with other substances, which also come with health risks of their own. The situation is no different with crystal meth. Finally, certain risks are associated more with the route of administration than with the drug itself, and these risks vary according to route.

People are of course far more varied and complex than laboratory rats. Results of laboratory experiments with animals can therefore not be interpreted like for like. Factors such as lifestyle, diet, genetic predisposition and comorbidity with other infections such as HIV can also have a major influence on the occurrence of illnesses and problems. In addition, many of the body's processes, and certainly those of the brain, are so complicated that science has not yet been able to identify all the factors that contribute to activity and disruption in the brain. And this is even more so with problems relating to mental health

1 <http://www.haveigotaproblem.com/download/273/Crystal-Meth-and-the-Brain>

than with physical problems, since many of the former's symptoms are subjective and the expressions thereof are determined more by personality, environment and culture than is the case with physical symptoms. It is often possible to state that the use of a particular substance has an effect on a particular process; for instance, prolonged use of crystal meth affects the dopamine system. However, conclusively proving that the use of a particular substance will lead to a particular illness is much more difficult.

Here follows an overview of the most important long-term effects of crystal meth, how often they occur, and the degree of certainty of the connection between crystal meth use and health problems⁽⁶⁾.

- **Poor sleep quality and sleep deprivation**

Frequency: common with chronic use

Certainty of connection: clear causal link

A loss of appetite and diminished pleasure in eating often lead to poor dietary habits. This eventually results in nutritional deficiencies, poorer general health and an increase in physical and mental stress.

- **Poor dietary habits**

Frequency: common with chronic use

Certainty of connection: clear causal link

A loss of appetite and diminished pleasure in eating often lead to poor dietary habits. This eventually results in nutritional deficiencies, poorer general health and an increase in physical and mental stress.

- **Stress and oxidative damage**

Frequency: common with chronic heavy use

Certainty of connection: there's some evidence

Chronic crystal meth use causes continuous stimulation of the sympathetic nervous system and thus a continuous stress response from the body and mind. Normal processes are disrupted and there is evidence of oxidative stress (imbalance in the metabolism of oxygen) in the blood and tissue. High dosage and frequency of use can lead to organ damage and premature aging. Oxidative stress is further associated with neurodegenerative diseases like Alzheimer's, Parkinson's and multiple sclerosis, as well as cardiovascular disease and the occurrence of certain forms of cancer.

- **Damage to teeth and gums**

Frequency: common with prolonged use

Certainty of connection: link established

Crystal meth causes an increase in tension in the jaw muscles. This can lead to teeth grinding (bruxism), which in due course may cause tooth damage. In addition, crystal meth induces extreme dryness in the mouth due to the inhibition of saliva production. This may eventually lead to inflammation of the gums, cavities and even tooth loss⁽⁹⁻¹⁰⁾. Reduced attention to oral hygiene as a result of taking crystal meth only makes this worse.

- **Paranoia and psychosis**

Frequency: relatively uncommon

Certainty of connection: some anecdotal evidence

Taking high doses in succession for several days can lead to paranoia and psychosis, the experience of which may sometimes last for days or weeks after the last occasion of use. Crystal meth use in combination with sleep deprivation increases the risk of paranoia and hallucinations (often auditory, visual or tactile). Chronic use of high doses can lead to long-term mental health problems. Research shows that once an individual has had one incident of crystal meth-related psychosis, they are likely to have another, whether as a result of drug use or other stressors⁽¹¹⁾.

- **Drying out of the mucous membranes**

Frequency: common

Certainty of connection: link established

Crystal meth causes the mucous membranes to dry out. This can lead directly to nosebleeds and dryness of the sinuses, throat and lungs, but also to vaginal and anal dryness. Functioning mucous membranes ensure that the tissue in question has a protective layer. Dryness of mucous membranes increases the risk of infection. Dryness of mucous membranes of the vagina and rectum increases the risk of the transmission of STIs.

- **Dry and itchy skin**

Frequency: unknown

Certainty of connection: some anecdotal evidence

Frequent crystal meth use is associated with dry and itchy skin. Frequent users of high doses of crystal meth report obsessive picking at the skin, sometimes until it bleeds.

- **Neurotoxicity**

Frequency: unknown

Certainty of connection: causal link established in mice, but precise nature unclear in humans

At high doses, crystal meth causes damage to the dopamine and serotonin receptors in the nervous system⁽¹²⁻¹³⁾. Prolonged use may result in significant neurological and behavioural problems. The connection between crystal-meth use and damage to the dopamine and serotonin receptors in mice is well documented, and also frequently confirmed in humans. However, a link between this damage and neurological and behavioural problems has not been demonstrated in humans⁽¹⁴⁾.

- **Breakdown of muscle tissue and kidney damage**

Frequency: uncommon

Certainty of connection: slight direct evidence

Prolonged use of high doses of crystal meth can lead to the breakdown of muscle tissue (rhabdomyolysis), usually as a result of overheating and overstimulation. This tissue breakdown elevates the levels of muscle proteins in the blood, which may lead to mild or even severe kidney damage⁽¹⁵⁻¹⁶⁾.

TOLERANCE AND WITHDRAWAL

Frequent crystal meth use leads to the development of tolerance. This means the user will need more of the drug or need it more often, or that the route of administration will need to change to achieve the same effect. Although crystal meth does not cause physical addiction – unlike heroin, GHB and benzodiazepines – regular users do indeed experience withdrawal symptoms when discontinuing use. The greater the level of tolerance, the more severe the withdrawal symptoms⁽¹⁷⁻¹⁸⁾. Withdrawal symptoms are usually due to a disruption of the neurotransmitter system. The symptoms are similar to those of other stimulants such as cocaine and amphetamine, but often last longer and are more severe in nature⁽¹⁹⁾. These symptoms often appear within twenty-four hours of the last dose⁽²⁰⁾.

Withdrawal symptoms (experienced by 87.6% of chronic users) typically result from chronic use of high doses, and the symptoms persist for about three to four weeks, with a so-called ‘crash’ phase in the first week⁽²⁰⁾. The most common withdrawal symptoms are anxiety and agitation, intense craving, depression (sometimes accompanied by suicidal thoughts), memory and concentration problems, fatigue, increased appetite, increased or decreased movement, lack of motivation, insomnia or sleepiness, and vivid or lucid dreams⁽²⁰⁻²¹⁾.

BIOAVAILABILITY IN BLOOD, DOSAGE AND DURATION OF OPERATION

The route of administration determines the percentage of crystal meth that eventually ends up in the bloodstream. A relatively large amount of the drug is lost when it is swallowed or snorted, as not everything is absorbed into the blood.

The actual effect is dependent on the ‘size’ of the dose and other factors such as tolerance developed due to regular use. The table below shows the typical dose per route of administration. These doses are based on the effects of unadulterated methamphetamine on subjects who haven’t developed any tolerance to the drug

2. Bioavailability

oral (swallowing)	62,7%
intranasal (snorting)	79,0%
smoking	90,3%
rectal (booty bumping)	99,0%
intravenous (slamming)	100,0%

3. Dosage

	Swallowing	Snorting
Light stimulation	5-15 mg	5-15 mg
Common	10-30 mg	10-40 mg
Strong	20-60 mg	30-60 mg
Very Strong (or with tolerance)	40-150 mg	50+ mg
	Smoking	Slamming
Light stimulation	10-20 mg	5-10 mg
Common	10-40 mg	10-40 mg
Strong	30-60 mg	30-60 mg
Very Strong (or with tolerance)	50+ mg	50-100 mg

The onset and duration of action is greatly determined by the size of the dose and the route of administration. The following times hold for individuals who haven’t developed any tolerance to the drug. Crystal meth is metabolised in the liver and excreted primarily in the urine. However, traces can also be found in the saliva and sweat.

4. Duration of effect

	Swallowing	Snorting
Onset	20-70 min*	5-10 min
Duration	3-5 hrs	2-4 hrs
Coming Down	2-6 hrs	2-6 hrs
Residual effect	up to 24 hrs	up to 24 hrs
	Smoking	Slamming
Onset	0-2 min	0-2 min
Duration	1-3 hrs	4-8 hrs
Coming Down	2-4 hrs	2-4 hrs
Residual effect	up to 24 hrs	up to 24 hrs

* Depending on the form of methacrylic and stomach contents

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4. SUMMARY: DATA ON CHEMSEX, CRYSTAL METH AND SLAMMING IN THE NETHERLANDS

CHEMSEX

Up-to-date national figures are lacking with respect to MSM and substance use in conjunction with sex (chemsex). Secondary analysis of EMIS's 2010 data shows that in 2010, Amsterdam ranked #4 in the top five European cities with the highest prevalence of chemsex.

CRYSTAL METH USE

In 2010, Amsterdam was also among the top five European cities with the highest rates of recent crystal meth use, according to secondary analysis of EMIS's 2010 data. Of the approximately one thousand Amsterdam-resident MSM surveyed, two per cent said they'd used crystal meth in the four weeks prior to the research, and five per cent in the previous twelve months.

In 2012, crystal meth use still stood at about 2 per cent, according to the Amsterdam Cohort Studies (the 'Gay cohort'). After 2012, participants stopped being asked about their use of crystal meth, until the question was restored to the questionnaire in the second half of 2015.

As with other chemsex drugs, national figures are lacking with respect to the current use of crystal meth by MSM. The recent data presented in this report was obtained from surveys among small, specific populations of MSM. This means that these figures can in no way be taken as representative of the general MSM population.

Since 2014, more has been learned about Amsterdam-resident MSM with very high-risk sexual profiles, who for this reason are part of the MS2 cohort. Chemsex is relatively common in this cohort. About 70 per cent of the participants used hard drugs, of which 90 per cent also did so in conjunction with sex. On the first cohort visit, nearly 13 per cent of the participants said they'd used crystal meth once or more in the previous six months.

From the total population of participants who attended MS2 consultations, 25 of the 148 (16.9%) had used crystal meth once or more in the period between January 2014 and April 2015. Close to 7.5 per cent reported having used it prior to three or more visits to the MS2 consultation. This indicates that the use of crystal meth has not remained a one-off among this group of men.

Although these are small numbers, the STI rate among crystal meth users in the MS2 cohort was higher on their first visit (52.6%) than among non-users of crystal meth (28.1%).

Another distinct group consists of HIV-positive men with a hepatitis C co-infection. In a MOSAIC study involving HIV-positive men with hepatitis C ('cases') and without hepatitis C ('controls'), seven per cent stated during their first consultation that they had used crystal meth in conjunction with sex in the previous six months (the first consultations occurred between 2009 and 2014, and marked the respondents' inclusion in the study). All but one of the men were from the 'cases' group.

SLAMMING DRUGS

In recent years the SOAP registration (survey conducted at STI clinics) has revealed a very slight increase in intravenous drug use among MSM that visit STI clinics, from 0.28% in 2011 and 2013 to 0.47% in 2014. The numbers are still small.

In the MOSAIC study involving HIV-positive men with hepatitis C ('cases') and without hepatitis C ('controls'), 5.6 per cent stated during their first consultation that they had taken drugs intravenously in the previous twelve months (the first consultations occurred between 2009 and 2014, and marked the respondents' inclusion in the study). This figure refers to the injection of any drug, not just crystal meth. All but two of the men were from the 'cases' group.

Examining the crystal meth figures in isolation, the MOSAIC study revealed that two of the fifteen men that used crystal meth took it intravenously (13.3%).

HIV AND HEPATITIS C STATUS

According to the EMIS 2010 report, HIV-positive men are more likely to use drugs during sex than HIV-negative men. The number of HIV-positive men who answered in the affirmative to the question of whether they had used chemsex drugs in the previous four weeks was five times higher than it was for HIV-negative men.

With specific regard to crystal meth, data from the MS2 cohort revealed that on their first visit, HIV-positive men stated that they had used crystal meth more often than HIV-negative men did (almost 17% of the former versus slightly more than 9% of the latter).

The MOSAIC study revealed that the majority of reports of having both used crystal meth and taken drugs by slamming were made by HIV-positive MSM with acute hepatitis C, while only a few of the HIV-positive men without hepatitis C reported this.

CONCLUSION

No long-term trends can be deduced on the basis of the above data.

The data reveals nothing about the frequency of using crystal meth and/or taking drugs by intravenous means (once, monthly, weekly or more often), nor about the use of drugs in combination.

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5. THE CONTEXT OF CRYSTAL METH USE



Different types of users within the crystal meth and slamming scene were interviewed for this research project. All respondents had had some experience with crystal meth use. However, there were huge differences in routes of administration, frequency and quantity of use among the various respondents. Consequently, there are also huge differences in the degree to which the men may have problems resulting from crystal meth use, if they have any at all. Some users also adjusted their intensity of use over time: some of the men would limit their use for a while when the adverse effects became too unpleasant. On other occasions, according to the men themselves, the enjoyment of the drug made them overstep their own boundaries of acceptable behaviour.

This chapter examines the specifics of using crystal meth: in which settings does it typically take place (section 5.1); the extent of the respondents' experience with crystal meth (section 5.2); to what extent crystal meth is used in combination with other drugs, and what other drugs (section 5.3); section 5.4 elaborates on the routes of administration of crystal meth. This section also focuses on slamming technique and dosage, safe slamming, the availability of slamming paraphernalia and the transition from smoking to slamming. Finally, section 5.5 discusses the crystal meth market, as well as its price and quality.

5.1 THE CHEMSEX SETTING

B. (42): "Crystal makes you overstep all boundaries."

Although the inclusion criterion was merely for respondents to have had some experience with crystal meth, all respondents turned out to have taken crystal meth in the context of chemsex. More than three-quarters of respondents use(d) crystal meth only in a sexual context, but not otherwise. The remaining respondents also use crystal meth in non-sex-related contexts. Thus some of the men sometimes used crystal meth when socialising; some used it every day, without the involvement of sex. Some of the men had only a bit of experience with crystal meth, but slammed other drugs during chemsex. The study focused not only on crystal meth, but also on the slamming of other drugs during chemsex. It's for this reason that this chapter focuses on experiences of slamming during chemsex in a more general sense.

F. (30): "When I went clubbing in Belgium, I used to duck into the toilets to slam. I was never caught."

M. (23): "It went horribly wrong in late 2014. I was slamming almost daily; all sorts of powders. I ordered the cheaper chems online, paying around €18 for five grams of 3-MMC, for instance. I used more than two grams on some days, culminating in twenty-five grams per week."

A. (43): "I only use when I'm having sex. I have some tina in a drawer as we speak, but I'm not sitting here thinking 'I have to use right now.' Sober sex can be hot, too."

For many of the respondents, chemsex is a part of their sexual lifestyle. Chemsex usually takes place within networks that meet for sex in conjunction with drug use. Half of the respondents participate in the so-called fetish scene (rubber, leather and latex) and engage in the more extreme sexual practices, such as BDSM, golden showers, electro, bondage, mind fucking and fisting. Within this subculture, chemsex under the influence of crystal meth usually takes place in a private setting, thus 'behind closed doors.'

All respondents were members of one or more sex networks. Some were small and private in nature, wherein members had contact primarily with other members. Others, such as the ones in which men found sexual partners via apps or dating sites, involved a fairly regular change of sexual partners. For most of the men who organised or attended chemsex parties, both the frequency of taking part and the duration of participation varied.

The nature and composition of a chemsex party depends on:

- Sexual preference and fantasies of the guests **"I never date and fist in large groups."**
- The specific drugs used **"Tina-users and users of other drugs tend not to get along."**
- The preferred route of administration **"Slammers always seek out other slammers."**
- Whether sex without condoms is the norm **"Large sex parties are by default bareback parties. What and how much you use are of less importance."**

Some respondents had a clear preference for one-on-one contact, while others preferred small groups of four to six men.

B. (60): "I always have my sex parties at my place; that feels safest. I turned one of my upstairs rooms into a playroom. I prepare the syringes downstairs, which is much better lit. My preference is for a small group of no more than four men. I'm a control-freak, so I find that more manageable. Some weekends are arranged well in advance, whereas at other times I date spontaneously."

H. (56): "I always organise my own sex parties and lay on a few escorts. The parties take place at home - mine or someone else's - or at a hotel, both in Amsterdam and abroad."

Some respondents organised or attended sex parties with larger numbers ranging from ten to forty men. These parties are often more open in nature than the smaller ones, with participants dropping in and leaving at different times. Contact is usually made through the various dating sites, where members can find what they're looking for via coded terminology for chems, barebacking, crystal meth and slamming.

P. (26): "I was recently at a tinsex party with thirty men. It began on a Friday evening and didn't stop until Monday morning. Half of us were from the Randstad, the other half from all over the country."

The length of time the respondents who attended chemsex parties were able to participate under the influence of crystal meth varied sharply. Some imposed a time limit on themselves out of self-preservation, knowing that the longer they carried on, the longer it would take to recover.

C. (49): "I slam every three weeks for no longer than ten hours each time. I need to know that I won't have to work the next day. That's simply not doable."

More than half of the respondents visited sex parties that went on for at least twenty-four hours and sometimes lasted for several days. In addition to the developed tolerance for the drug and the route of administration, the individual's physical condition and extent of their responsibilities in daily life influenced how long they carried on for. The frequency and duration of chemsex sessions also varied within an individual's life as a user. Sometimes the frequency and duration would rise over time until the sex weekends began earlier and ended later. Whereas there were also cases whereby individuals would lower their frequency of use because it was starting to have too great an impact on their daily lives.

B. (37): "I use almost every weekend - often 4-MEC and occasionally tina - and keep going till Sunday morning or afternoon. I once carried on for four days, but coming down was far too intense."

B. (32): "In 2012 I went for three months non-stop on tina. Secluded in my room and sat at the computer every day, completely focused on sex. I was smoking three grams per week on average, and would go without sleep for four or five days."

5.2 EXPERIENCES WITH CRYSTAL METH

The year of the respondents' first occasion of using crystal meth varied (see table 1). Most of the respondents (18) took the drug for the first time after 2010, peaking in 2012 (6). Four respondents were abroad when they first took it (USA, UK, Germany, Asia), and they all did so before 2005.

M. (30): "I was in Berlin the first time I used crystal meth. I wasn't familiar with the drug and didn't know what to expect. Its effect was indescribable. All my inhibitions vanished, and I was free to totally cut loose."

1 First occasion of using crystal meth

Year	Number
< 2005	3
2006	1
2009	1
2010	3
2011	5
2012	6
2013	4
2014	2
2015	1
Planning to use	1*
Total	27

* This respondent had never used crystal meth before the interview, but planned to do so in the near future. However, he had had a lot of experience with slamming.

The respondents had very different levels of experience with using crystal meth. About one-fifth of respondents had experimented (once or a few times) with crystal meth but not thereafter. They found it too intense, especially the coming down. These respondents didn't plan to try crystal meth again in the future, preferring to stick with other drugs.

G. (53): "I stopped taking crystal meth after trying it once, because of the severe after-effects. I felt great for twenty-four hours but it took me three or four days to recover. That tipped the balance to negative, in my view."

One-quarter of the respondents monitored their use and claimed to use it only recreationally. They used crystal meth from anywhere between several times a year to once a month and prepared carefully for chemsex sessions. More than half of the respondents had sometimes experienced problems related to taking crystal meth or slamming other drugs (4-MEC, 4-FA, mephedrone). One respondent was heavily dependent on crystal meth during the period in which the interviews took place, and five of the men were undergoing rehabilitation treatment. Because contact was maintained with the respondents following the interviews, we know that all of the men who described themselves as clean during the interviews relapsed after short or long periods of abstinence. Some said they now had better self-control, while others intended to use in greater amounts and more often.

5.3 COMBINATION USE

All respondents had had some experience with combination use. Crystal meth is taken with a wide range of substances. Downers such as ketamine, GHB or GBL

are the substances mentioned most often in connection with combined use. Eight respondents had a preference for combining crystal meth with GHB or GBL. Four always combined it with ecstasy, usually to get in the mood for chemsex. According to the respondents, the popularity of the upper mephedrone was growing in the Netherlands, following in the footsteps of the UK. Five respondents said they took this combination regularly. Three respondents named crystal meth their favourite drug, and only combined it with erectile-dysfunction drugs, rarely with anything else. One respondent sometimes took it in combination with LSD.

The adverse effects of crystal meth, such as muscle tension and restlessness, were often neutralised by substances with a more relaxing effect, such as GHB and ketamine. The men had typically tried all sorts of substances, rejecting the ones that resulted in unpleasant experiences.

C. (49): "I had such horrible experiences with GHB and ketamine that I stopped taking them. But it's never gone wrong with tina, so that's what I use."

A. (44): "Crystal with GBL is the best combination for me. GBL mutes the jacked-up effect you get from crystal. You can have hour-long, energetic and super horny sex. Crystal also goes well with benzos or ketamine, though it's difficult to work out the correct dose of ketamine."

2 Favourite drug to use in combination with crystal meth

Drug	Number
GHB	5
Ecstasy	4
GBL	3
Mephedrone	3
Ketamine	2
LSD	1
Total	18

About a quarter of respondents didn't use or no longer used crystal meth, preferring other drugs, which they did not necessarily slam. Some now took mephedrone or ketamine. Others avoided these drugs specifically because of adverse effects such as the loss of consciousness or the severity of coming down. Some still had chosen the new psychoactive substances (NPS), such as 4-MEC, 3-MMC or MXE.

T. (44): "Mephedrone doesn't have as long-lasting a rush as tina, but its bad after-effects are significantly less drawn-out. Same goes for slamming 4-FA."

B. (29): "My absolute favourite is slamming ketamine into the muscles. It's trippy and you suffer few adverse effects in comparison to crystal."

P. (51): "My favourite is 4-MEC. It makes you super horny, gives you a powerful rush and lots of energy. I rarely suffer after-effects or a hangover. It's much nicer than crystal meth."

M. (42): "I now prefer slamming mephedrone or 3-MMC. They give you more or less the same rush as tina, but the effect doesn't last as long, and coming down is less severe."

ERECTILE-DYSFUNCTION DRUGS

Almost all respondents took erectile-dysfunction drugs prior to or during chemsex. Many took these drugs because they found it difficult to have and/or maintain an erection on crystal meth. Viagra and Kamagra were mentioned most often.

A few said they never took erectile-dysfunction drugs. They said they were able to have and/or maintain their erection on crystal meth, and/or that during chemsex they engaged in sexual practices that depended less on having an erection, and/or that they didn't aim to climax. Seven respondents had self-injected Androskat, a drug that increases blood flow in the erectile tissue when injected into the penis.

C. (30): "I typically take two Kamagra pills an hour before slamming tina. This keeps my dick hard when I want to fuck."

P. (51): "I find Androskat much better than Viagra or Kamagra. It keeps you going for hours. You maintain your erection even when reading the papers. But I've also heard tales of things going wrong, of people having to be taken to hospital in an ambulance. Stay erect for too long and you run the risk of permanent damage."

5.4 ROUTES OF ADMINISTRATION

Crystal meth can be taken in a number of ways. Both the intensity and effect of the drug are determined largely by the route of administration. Besides snorting, crystal meth is typically smoked through a glass pipe with a bowl at one end, rectally inserted with a needleless syringe (booty bumped) or injected (slammed). Crystal meth is mostly slammed intravenously. Other drugs are also sometimes injected subcutaneously (under the skin) or intramuscularly (into the muscle).

Snorting crystal meth has the least effect; slamming the greatest. The frequency of use and amount used per session depends on the user's experience, level of tolerance, the extent of their psychological dependence and the strength of their craving.

B. (29): "The method determines the effect. I've snorted, smoked, booty bumped and slammed. Each method has a different effect."

SNORTING

When snorted, the effect is felt after about five minutes, and the intensity of this effect lasts for a couple of hours, depending on the dose. One respondent preferred snorting it because this method delivered a more gradual effect than smoking or slamming. Some of the other respondents had snorted crystal meth when socialising outside the home, clubbing or in a home setting. However, they preferred smoking or slamming when having chemsex.

J. (29): "I always snort crystal. You take it in better that way; it's more relaxed and the effect is long-lasting. I find smoking too intense, let alone slamming."

SMOKING

Six of the men smoked crystal meth. The effect is felt very quickly when smoked, as it is when slammed. The rush (the surge of the effect) is less intense than it is with slamming. This is because you can't smoke as much crystal meth in one go as you could if you injected it, and because it enters the bloodstream less rapidly when you smoke it. Some of the men had slammed, but smoking was their clear preference.

The men who used less frequently said they typically took a hit from a pipe every half hour, and that they could smoke up to one gram with a sexual partner over a period of a day and a half. More experienced smokers, who'd developed some tolerance, smoked faster. Habituation builds quickly, according to several respondents who said it hadn't taken them long to need more to achieve the desired effect.

The smokers had all sorts of techniques for consuming the drug as efficiently as possible. For example, they had tricks for cooling the pipe after heating (with a wet washcloth) to prevent what was left in the pipe from smouldering. Or they'd plug their pipe to prevent the smoke from escaping, or recycle their exhaled smoke by capturing it in a plastic bag.

According to the smokers, the important thing was not to let the crystal meth get too hot; otherwise it would burn and taste bitter. To derive the maximum effect from smoking, most of the men would hold the smoke in their lungs for as long as possible. Some of the men shared their meth pipes. Others said they didn't, and kept their smoking paraphernalia hidden from other smokers. Some respondents said they were aware of the risk of hepatitis C transmission posed by sharing crystal meth pipes.

A. (44): "I take another hit every thirty minutes, on average. That's how you build the desired positive effect. Of course the effect also depends on how much and how often you use. Some men smoke a pipeful every fifteen minutes."

BOOTY BUMPING

When crystal meth is taken via the rectum, it enters the bloodstream via subsurface capillaries in the mucous membrane lining the rectum and colon. As a result, absorption into the bloodstream occurs gradually in comparison to smoking or slamming. This makes for a less powerful rush, although the amount absorbed is actually higher than is the case with snorting or smoking (see section 3.1). Five of the men had booty bumped crystal meth. The method had its benefits for some of the men. Others were less enthusiastic about booty bumping, citing a preference for other routes of administration. Crystal meth is an expensive drug, so its users often seek to derive the most intense rush from taking it, which smoking or slamming deliver. Booty bumping is a popular method for taking other drugs, such as ketamine, mephedrone, cocaine and 4-MEC, as these are less expensive than crystal meth.

M. (42): "Besides smoking and slamming crystal, I've also booty bumped it. But you don't get as great a hit from that, so I no longer take it that way. It's too expensive for that."

SLAMMING

Twenty of the respondents had taken drugs intravenously, sixteen of whom had slammed crystal meth. All but four slammed for the first time after 2010. Three of the four had already slammed by 2005, all abroad. Five of the sixteen men that had slammed crystal meth had taken the drug in this manner once or twice, and had decided to avoid slamming it again because they found its effect too intense and overwhelming. They preferred smoking it instead and/or slamming other drugs, such as ketamine, 4-MEC, 3-MMC, cocaine, MXE or 4-FA.

Eleven of the respondents slammed during the period in which the interviews took place. The frequency of use and size of dose varied by respondent. The frequency and dose per sex session were dependent on the duration of the sex session, user experience, level of tolerance and dependence, and the quality of the crystal meth. The dose per slam among all respondents ranged from one hundred milligrams to a maximum of four hundred and fifty milligrams.

A. (44): "I've slammed tina twice, but found the effect much too intense. Within seconds of injecting, I felt a violent flash shoot through my system, like an electric shock from head to toe. I became very restless, and all my senses were wide open and on full alert. External stimuli flooded in much too intensely. That's why I prefer to smoke."

3 First slamming experience

Year	Number
< 2005	3
2006	-
2007	-
2008	-
2009	1
2010	-
2011	5
2012	4
2013	2
2014	4
2015	1
Total	20

In comparison to the amounts in table 3 in Section 3.1, which are based on users with no built-up degree of tolerance taking pure methamphetamine, the doses taken by the respondents above are significantly higher. This might be a reflection of the respondents' degree of tolerance or of the low potency of their crystal meth due to adulteration.

In the summer of 2014, Mainline asked the test lab at the Trimbos Institute in Utrecht to test a sample of street-obtained crystal meth. The sample turned out to have a purity level of seventy per cent, which is relatively high. According to some respondents, the crystal meth obtainable in Germany is often of significantly higher quality. This is perhaps because it is less adulterated. If a user takes their usual dose without taking into account the difference in levels of adulteration, it can have an undesired effect or even cause a serious overdose, particularly when slamming.

M. (42): "I overdosed on a chemdate in Mexico. I took the same amount as I normally do here [in the Netherlands], but their tina is much stronger. I began to shake violently and my vision began to fade. I thought my heart was about to explode, and I panicked and ended up in hospital."

SLAMMING TECHNIQUE AND DOSAGE

The procedure for preparing syringes within the chemsex scene is broadly similar to that followed by heroin users, except for two differences: a) you don't need to dissolve crystal meth in acid; it dissolves readily in water, and b) Dutch slammers tend not to filter their solution, except for an isolated few who follow their own methods. Filtering the liquid prevents the injection of undissolved particles into the veins and/or the needle from clogging. The preparation procedure for slamming within the chemsex scene involves tipping the desired dose in powdered form into the barrel of the syringe and dissolving it in distilled or boiled water by giving the mix a good shake for a fairly long time. All respondents used thin needles meant for

administering insulin injections. The slammers said they started with an initial dose of about a hundred milligrams, and built up over time to three to four hundred milligrams per slam.

C. (43): "I slam between the 1.5 and 4.5 mark [on the syringe] of finely powdered meth per session, but the 4.5 mark is really the maximum. I'd overdose otherwise. I dissolve the powder in cooled, boiled water. The crystals dissolve easily when you give the syringe a good shake. If any undissolved crystals remain, I remove the needle and draw the liquid with a new needle, which filters out the grit."

In the beginning, most men have no idea how to prepare and/or administer a slam. The first slam was not something most users had given much prior thought or prepared for. Many simply learned from other more experienced slammers at sex parties. But there was often a lack of knowledge of safe and correct slamming at that first learning occasion. And in the early days of their slamming life, they would typically leave the preparation to their more experienced sexual partner or to anyone with medical knowledge or a medical background who happened to be present.

M. (23): "After a while I wanted to learn how to slam. I found the correct way to slam on American slamming sites, and that's how I learned."

Eventually, most men learn how to prepare a slam. Some of the men reported searching online for more information about slamming, but more often than not users learn how to slam from other users within the scene. This results in local differences in method and creates the potential for learning incorrect techniques. Observing this in practice was outside the parameters of this study, but the respondents' stories suggest a lack of comprehensive knowledge of correct slamming techniques. The practice of filtering the liquid solution is a good example of a local difference between Europe and the US. None of the Dutch respondents filtered the solution after preparing the mix. British colleagues confirmed that this is rarely done in the UK, either. Meanwhile filtering is a common procedural step in the US.

M. (42): "I don't know anyone who filters their chems. You do see that in the States, but that's senseless, in my opinion, 'cos you can catch cotton fever from cotton filters."

Respondents also mentioned procedural habits that they couldn't explain when questioned. For example, setting the prepared syringe in warm water. Sometimes respondents gave incorrect explanations for the occurrence of certain problems, such as abscesses. Abscesses are almost always caused by the unhygienic use of injecting paraphernalia.

H. (54): "I often see men with bruises on their arms. I don't get those. If you slam alongside or into the vessel wall, you develop abscesses; I've never done that."

More than half of the respondents who slammed said they regularly witnessed other users slamming with questionable technique, which they put down to ignorance, or to carelessness as a result of slamming under the influence of crystal meth during prolonged periods of slamming, which can last for days. In some cases, users would criticise other users' poor slamming technique, while they themselves failed to observe the correct procedure.

Almost all respondents claimed to know the correct procedure for slamming once they'd been doing it for a while. They often had their own personal slamming kit with all the necessary paraphernalia: alcohol wipes for disinfecting the point of insertion, tourniquets for raising the veins, insulin syringes with thin needles for dissolving unfiltered chems, and gauze dressing for sealing slam wounds. Six respondents said they'd eventually assumed the role of slamming expert and often or always injected their sexual partner(s).

R. (59): "Good Slamming technique is an art. I messed up the first time I slammed and my arm was covered in bruises. One of my sex buddies has lots of medical knowledge and a private course in 'professional slamming'. My technique has been flawless ever since. I always do my own slamming, and sometimes inject the other person too."

The largest group of respondents said they were pretty strict about using only their personal equipment and discarding needles and syringes after a single use. They said they didn't share equipment with anyone else under any circumstances. If they didn't get the slam right the first time, they discarded the needle and tried again with a new one.

Four respondents had shared needles. But unlike heroin users from the eighties, where sharing out of necessity was not uncommon, the sharing of needles and blood that goes on here is deliberate. This deliberate needle sharing takes place in the 'brotherhood', a subgroup within the slamming scene. According to the respondents who identify with this brotherhood, this particular internationally oriented group is relatively small in the Netherlands. These individuals often describe needle sharing as 'the ultimate form of connectedness.' Thus needle sharing is the exception rather than the rule, and the practice is generally frowned upon in the slamming scene. The other respondents who slam, described the practice as 'very unattractive', 'not done' or 'highly destructive'.

T. (44): "I'd been fantasising about sharing blood and eventually did it with two of my regular sexual partners. The kick was enormous! To actually enact this fantasy without inhibition. Delightful. Having said that, I have no idea why it's so arousing."

B. (29): "I'd heard of the brotherhood, but felt that was really taking things too far. I love taking risks, but sharing blood goes way beyond my limit. I doubt I'll ever fathom what people get out of it. I find it repulsive, actually."

ACCESS TO SLAMMING PARAPHERNALIA

Most of the respondents bought their syringes and other paraphernalia online. Others got their syringes from their primary sexual partner(s). One individual bought from a medical specialist or pharmacy; this usually occurred when the occasion of use was unplanned, or if he ran out of supplies during a slamming session, which ruled out ordering online. Four respondents had occasionally been viewed with suspicion at pharmacies, and/or had encountered an unwillingness to sell them clean syringes.

L. (35): "Getting hold of clean needles is sometimes quite a hassle. You come across pharmacists who refuse to sell you needles or grill you about what you want to do with them. That doesn't seem right. Ordering online is so much easier; the only downside is that you don't have them to hand immediately."

Ten of the twelve active slammers didn't have a dedicated container with a lid for the safe disposal of used needles. The stated reason was that they didn't give any thought to the consequences of chucking used needles away with the regular garbage. The largest group threw their used needles and syringes in the dustbin. Needles were typically disposed of in containers with a lid; a few bent the needles before disposing them. This group was not aware of the potential risks to third parties. One respondent said a cleaner had pricked himself when emptying out the garbage. Most respondents did not know local needle exchange programmes even existed, let alone how they worked, where they were and when they opened. Those who were aware they existed didn't use them out of shame and fear of being labelled a 'junkie'. However, indifference and complacency also appear to play a role.

N. (53): "There are no clear directives telling you not to chuck your used syringes unprotected in the garbage. It's irresponsible to do that. I tell people to place protective caps on their used needles and stick them in empty plastic bottles or juice containers before binning them."

The first ten interviews in this study revealed that there's a basic lack of knowledge of safe slamming among respondents and/or the men they met at slamming parties. Based on user-experience stories, Mainline published the booklet '**Slamming: dos & don'ts**' in collaboration with users in March 2015. It offered inexperienced slammers information and tips on correct slamming technique and safer use, as well as practical information on drug-induced psychosis and managing the coming down experience. The booklet is available to users and professionals both in printed and digital form. Some respondents now include the link to the digital version in their online dating profiles.

FROM SMOKING TO SLAMMING

According to most of the respondents, smokers and slammers tend to operate in different sexual networks, although some crystalmeth and bareback parties are attended by both smokers and slammers. Almost all of the respondents with slamming experience began using crystal meth by smoking it. And despite the initial resistance to slamming experienced by some of the men, their doubts eventually receded due to the pressure of group dynamics. The enthusiasm with which other users talked about their experiences and witnessing the effects of slamming piqued their curiosity enough for them to try it themselves. The constant urge to push boundaries and experience new thrills also played a role in making them take this step, according to respondents. Most 'switchers' cited the more powerful rush delivered by slamming as their main reason for switching from smoking to slamming.

M. (23): "I saw others experience the rush from slamming tina and I asked them how it felt. The answer was always: 'Indescribable.' So, after a while, I crossed the line, and the effect was overwhelming. All inhibitions evaporate when you slam."

C. (43): "I smoked tina in my first year of use, but I became increasingly curious about slamming. Its effect is overwhelming. The euphoric high, massive horniness and intense rush that flows through your body is indescribable. The arousal delivered by smoking is magnified ten to a hundred times when you slam."

Eight respondents stated very strongly that they had no interest in ever slamming. They felt slamming was 'not done', and saw it as the furthest border across which they had no desire to ever step, or are ever likely to step. Some respondents had slammed once and left it at that.

A.(43): "Slamming goes beyond my limits. Nevertheless, it's quite fascinating to see other people experience that intense boost of energy they get from slamming."

Five of the slammers injected other drugs rather than crystal meth; ketamine, cocaine, 4-MEC, 3-MMC, 4-FA, MXE and mephedrone were the ones most often

mentioned. They found crystal meth too expensive, its effect too intense, and coming down from it too severe and protracted. The other drugs delivered less extreme effects and dips.

B. (29): "In my experience, ketamine is the most pleasant chem. I like to slam into the shoulder muscles. If you gauge the dose correctly, colours and sounds start to change, and it's like you're in paradise. But tina is different. It's extremely expensive and its effects are far too intense. I really don't understand why it's becoming so popular."

5.5 THE MARKET, PRICE, QUALITY AND AVAILABILITY

All respondents were asked how many other crystal meth users they knew. The number, varying from five to two hundred, was largely determined by the extent of the respondent's participation in different subgroups within the gay scene, whether they themselves regularly slammed, and in what way they were active in chemsex networks. Some respondents said they almost always had chemsex with the same group of men while others were active in more fluid sex networks wherein a continuous influx of new men was the norm.

Although it's impossible to offer an estimate of the size of the group of crystal meth users and slammers in Amsterdam and/or the Netherlands on the basis of the interviews, the respondents and other sources [in the field]¹¹ were unanimous in their conviction that taking crystal meth and slamming drugs were growing phenomena in certain subgroups within the Dutch gay scene. One dealer in Amsterdam said he currently has around a thousand regular crystal meth customers, and that his clientele has expanded enormously over the last three years. Over eighty per cent of his clientele consists of MSM. According to him, at the time of the interviews there were at least eight other dealers in Amsterdam who sold crystal meth. And fieldwork and dating sites indicate how easy it is to find men who are interested in crystal meth and/or slamming. This reinforces the impression that it is no longer a niche.

A. (44): "In the nineties, everyone used ecstasy; after the millennium, half the city was on GHB; and now it's increasingly tina. Crystal meth is snorted or smoked even at international gay parties in Amsterdam and Brussels."

H. (56): "I've witnessed an explosion of tina-use within both the gay and the escort scene. I know at least two hundred men who use it. And if you look at it statistically, Amsterdam has 800,000 inhabitants of which ten per cent are gay. Say half are lesbians, half gay. If only one or two per cent of all those guys use crystal meth, that works out at five hundred to a thousand men."

The interviews suggest that crystal meth was hard to come by in the Netherlands until 2011. All nine respondents who had already experimented with crystal meth by that time claimed there were only a handful of active dealers in the country before 2010. But from 2011, there was a corresponding growth in demand and supply in the Netherlands. Today, according to some respondents, Amsterdam alone has eight to ten dealers, making it easier than ever to score crystal meth. According to respondents, there are fewer dealers in other major cities such as The Hague and Rotterdam. Men from the east and south of the country said they bought their crystal meth in Germany, namely in Cologne, Frankfurt and Berlin. Their reasons were: ease of availability, low price and high quality. Some of them then sold it on in the Netherlands. Some of the men had it sent to them from the United States, or travelled there to use it.

The price of crystal meth has dropped in the last few years. This could be an indication of an increase in supply and demand. Since 2011, the street price of crystal meth has gradually fallen from two hundred to one hundred and fifty euros per gram. A few dealers are now even asking one hundred to one hundred and thirty euros a gram. Some respondents reported buying at even lower prices when they purchased larger quantities in one go.

L. (35): "My gear is of high quality and comes from Germany. I used to pay two hundred euros two years ago, then one hundred and seventy-five, then one hundred and fifty. The rule is: the more you buy, the cheaper the price per gram. I usually buy ten grams and share it with friends. So I end up paying only one hundred euros per gram."

A. (43): "One of my crystal meth dealers has been selling tina to a broad clientele for years. Since he discovered the gay scene as a growing market, his turnover has trebled."

There are also dealers offering crystal meth for ninety euros or less per gram on various MSM dating sites. Those respondents who had bought from this source found the quality of the product to be very poor and said they had experienced a variety of adverse effects during or after use

A. (43): "I recently bought some stuff online that turned out to be bad. What we experienced was the complete opposite of what I'd expected. We felt groggy, queasy and lethargic rather than wide awake and energetic. Whatever we took was definitely not tina."

The ongoing nationwide drop in the price of crystal meth was a cause for concern for many respondents. They were convinced that a lower street price would make the drug more popular within the chemsex scene. They felt that anyone curious about the drug was more likely to try it sooner. A few of the respondents felt that the high price

¹¹ Such as peers, headshop employees and crystal meth dealers

encouraged current users to exercise more self-control in both frequency of use and in the size of the doses they took. In their opinion, a falling price could lead to an even greater increase in new users and to an increase in frequency of use among current users.

B. (37): "One gram of crystal meth costs between one hundred and one hundred and seventy-five euros. If it becomes considerably cheaper and more widely available, I'm sure I'll use more often. I find it very expensive at the moment because I'm on benefits."

None of the respondents had had their crystal meth or other drugs tested at a testing facility (in the Netherlands people can have their drugs tested at an addiction care facility). Many respondents bought from a regular, and in their opinion reliable, home-delivery dealer who always had drugs of decent and consistent quality. Tips about crystal meth quality and about which dealers were dependable were exchanged within personal sexual networks and online. Most new chems (mephedrone, 4-MEC, 3-MMC, 4-FA) - which in most cases were not (yet) on the list of banned substances - and erectile-dysfunction drugs (Viagra, Kamagra) were purchased online. All respondents assumed that these were of good quality.

SUMMARY

Three-quarters of the respondents only use/used crystal meth in connection with sex. This use occurred mostly within chemsex networks, in which the more extreme sexual practices also often took place. All respondents were participants in one or more sex networks. The sex networks varied in size and degree of openness. Contact was often made through the various dating sites for gay men, where coded language was used to indicate the desire for chemsex, barebacking, crystal meth and slamming.

More than half had sometimes experienced problems related to using crystal meth, or to slamming other drugs. Most respondents, who'd only tried crystal meth once or twice, cited the severity of coming down as the decisive factor in swapping crystal meth for other drugs.

All respondents had some experience of combined use. The most often mentioned form of combined use was a mix involving downers such as ketamine, GHB or GBL. Almost all respondents used erectile-dysfunction drugs prior to or during chemsex.

Crystal meth is used in different ways. The route of administration largely determines the intensity and the effect of the drug. The most popular routes are smoking and slamming (injecting). Some men reported sharing meth pipes with other users. A few were aware that sharing meth pipes carried the risk of hepatitis C transmission.

Twenty of the twenty-seven respondents had used drugs intravenously, including sixteen who had done so with crystal meth. Many of the men had had no experience of using drugs intravenously before their first slamming experience. Users learned how to slam from other users in the scene. As a result, incorrect slamming technique was often learnt and passed on.

Users often bought their syringes and other paraphernalia online. When the occasion of use hadn't been planned in advance or if users ran out of supplies during a slamming session, supplies would be replenished at the local pharmacy. When this happened, users sometimes encountered reluctance to sell to them and/or suspicion. Needle disposal containers were rarely used and most respondents were not aware of the existence of needle exchange programmes or how they worked, nor were they aware of where their local facility offering this service was located or when it opened.

Almost all of the men that had slammed crystal meth had initially smoked it. Doubts about slamming receded due to pressure created by group dynamics. Witnessing the experience of other users and a desire to push boundaries also appear to play an important role here. The more powerful rush experienced on the first occasion of slamming is usually the reason to switch from smoking to slamming crystal meth.

Although it is difficult to estimate the size of the population of crystal meth users and slammers, the respondents and other informants were unanimous in their conviction that crystal meth use and the slamming of drugs were growing phenomena within certain MSM subgroups. A continued fall in price could lead to a greater increase in the number of new users as well as an increase in the frequency of use and/or size of doses among current users. NPS are always bought online. None of the respondents had had their crystal meth or other drugs tested at a testing facility.

6. HIV, HEPATITIS C AND OTHER STIS



Using condoms during sex is the most effective way to prevent the transmission of HIV and other STIs. Yet condom use was low among the respondents in this report. According to them, condoms are rarely used in the crystal meth and slamming scene.

In section 6.1 we examine the reasons why the respondents rarely use condoms. Thereafter, in sections 6.2 and 6.3, we describe the risk perceptions and risk-taking behaviour of the HIV-seronegative and -seropositive respondents. Section 6.4 looks at hepatitis C and other STIs, as well as the testing habits of all respondents. Section 6.5 looks at how HIV-positive respondents cope with their diagnosis and status. Adherence to HIV therapy is discussed in section 6.6.

6.1 ANAL SEX WITHOUT CONDOMS

Ten of the respondents were HIV-negative and seventeen were HIV-positive. Fourteen respondents said they never used condoms and thirteen said they sometimes did. None used condoms all the time. Barebacking was a matter of principle for the fourteen men who never used condoms. It was a conscious choice independent of their substance use. Some have had condomless sex their entire lives. Some found it unnatural or uncomfortable to have sex while wearing a condom. Others didn't consider it 'real sex'. Some cited latex allergies or problems with fit as the main reason for not using condoms.

L. (35), HIV-positive: "I'm making a conscious choice to bareback when I have sex. I simply cannot fuck if I wear a condom. Safe sex isn't fun."

M. (42), HIV-positive: "Barebacking is simply more pleasurable and more natural. This is a conscious choice. I'm always open about my HIV status, even when internet dating. And if someone turns me down because of it, that's fine. I prefer to be open about everything."

K. (46), HIV-positive: "I bareback 99 per cent of the time. I only use condoms when I have sex with a few of my regular HIV-negative sex mates."

1 condom use

Always	-
Sometimes	13*
Never	14
Total	27

* At sexual partner's request and dependent on HIV status

In addition, some respondents said that even when they planned to use condoms, this intent often evaporated after using crystal meth and/or slamming. The reasons given for why this happens were: the norm of barebacking, the blurring of boundaries due to drug use, and getting carried away by the euphoria and carelessness brought about by being under the influence of the drug. Also mentioned

were practical obstacles such as the incompatibility of sex sessions that go on for days and the continuous changing of condoms. Although the precise relationship between condom use and the use of crystal meth and/or slamming is not clear, it is arguable that these factors do not encourage condom use.

A. (44), HIV-positive: "Meth makes you overstep all your sexual boundaries. Even if you're firm in your intent to fuck with a condom, this intent simply crumbles with tina."

A. (43), HIV-negative: "Barebacking and crystal meth always go hand-in-hand. I know of no exceptions and have never seen anyone put on a condom while on crystal meth. I don't know a single meth user who practices safe sex."

6.2 THE RISK PERCEPTIONS AND SEXUALLY RISKY BEHAVIOUR OF HIV-NEGATIVE RESPONDENTS

All ten HIV-negative men declared a preference for barebacking. In most cases, they openly discussed HIV-status and viral loads with other sexual partners prior to sex dates. Most of them were aware that it was possible for HIV-negative partners to have contracted HIV without being aware of it themselves. They expressed a preference for having condomless sex with HIV-positive men with an undetectable viral load because in so doing they were highly unlikely to contract HIV, and thus they could bareback without concern. Respondents were aware that they still risked contracting other STIs by having condomless sex. However, they saw this risk as something that comes with the territory of barebacking.

B. (37), HIV-negative: "I always have safe sex when it's with HIV-positive men who are not on medication. You're playing with fire otherwise."

N. (53), HIV-negative: "In an environment where everyone is on antiretroviral drugs, I consciously choose to bareback. Almost none of my regular sexual partners are HIV-negative. I always go for HIV-positive men on medication."

Another respondent said he rarely or never discussed anyone's HIV status with his sexual partners, but used his intuition to decide whether or not to go condomless. When it felt right, he barebacked.

P. (26), HIV-negative: "I screen my sexual partners intuitively for HIV and STIs. It's worked brilliantly so far. If my partner is HIV-positive but takes his medication unfailingly, I'll bareback regardless. Most of the men I know who have chemsex are already HIV-positive. I never let others come in me. That's where I draw the line. Perhaps that's why I've been able to get away with it so far."

One HIV-negative respondent who had been a sex worker for years always used a condom with clients, regardless of whether or not he was under the influence. But he regularly had condomless sex in his private life. The size of sex parties determined the extent to which HIV status and viral load were discussed. The respondents said that in small, private sex parties (with four participants on average) where all the sexual partners know one another, the level of candour about everyone's HIV status is generally high and that the participants typically inform the others in advance. The likelihood of sharing this important information decreases with bigger and lengthier sex parties. Men typically arrive, join in and depart throughout the party, with new participants finding out about ongoing parties via dating apps and websites. Consequently, any monitoring of participants' HIV status soon breaks down and discussions about HIV status are simply less likely to happen.

In addition to discussing and sorting according to HIV status and viral load, HIV-negative respondents had other strategies for reducing the risk of contracting HIV. For instance, three respondents said they usually played the active, penetrating role, making them less likely to contract HIV than if they assumed the role of the passive, penetrated party.

B. (42), HIV-negative: "I engage in fisting, and I usually fist unprotected. I do check in advance with alcohol to see if I have any cuts on my hands. But you're still gambling with safety when you fist. What I find remarkable is that most of the younger guys don't seem to give much thought to HIV, and always bareback."

Some HIV-negative men who assume the passive role try to lower the risk by not allowing their partner to ejaculate inside them. It's not clear to what extent the risk-reduction strategies are actually implemented by the respondents when under the influence of crystal meth or other substances. Some of the men said they often had rougher sex when they used crystal meth or slammed, and worried about the risks they'd taken afterwards. Half the HIV-negative respondents sometimes worried about the risk of contracting HIV. The other half gave it little thought and saw the risk as a logical consequence of their conscious decision to bareback.

P. (26), HIV-negative: "It would definitely suck if I contracted HIV, but it'd be my own fault."

6.3 THE RISK PERCEPTIONS AND SEXUALLY RISKY BEHAVIOUR OF HIV POSITIVE RESPONDENTS

Seventeen respondents were HIV-positive. Two of them said it was likely they'd contracted the infection while under the influence of crystal meth. The remaining fifteen said their HIV status had nothing to do with crystal meth as they'd contracted the infection before ever using the drug. The HIV-positive respondents had a strong preference for sex without condoms.

Some of the HIV-positive men only used condoms when their partners were HIV-negative and as a result wanted them to use condoms. Three-quarters of HIV-positive men would rather have sex with an HIV-positive partner. Although an undetectable viral load means the chances of them infecting their sexual partners are minimal, serosorting allows them to avoid having to worry about this at all.

Most HIV-positive respondents were open about their HIV status and mentioned it in their online dating profiles, and they expected a similar degree of candour from their sexual partners. Some respondents said they broke off online contact if a potential sexual partner was reluctant to disclose their HIV status. The discussion about HIV often took place prior to sexual partners meeting in person and outside the sexual setting, and the men usually knew each other's HIV status before arriving at the location.

K. (46): "We only attend sex parties where we know everyone else's HIV status in advance, and they ours. It's not the ideal subject to hold off discussing until you're already at the party."

The HIV-positive respondents said that when the sexual occasion occurs spontaneously (for instance, when men meet each other for the first time when they're out socialising and go home together along with other new acquaintances they might have invited along), they don't usually know each other's HIV status.

A small number of HIV-positive respondents did not reveal their HIV status on a consistent basis. One man didn't reveal his status even when asked, as he was convinced that he posed no danger to others because his viral load was undetectable. These men also believed the decision to bareback is each person's responsibility. Barebacking was the rule rather than the exception for the two HIV-positive men who engaged in sex work. They felt the responsibility for using condoms was up to the customer.

B. (32): "I'm usually open about my HIV status when I engage in sex work, at least if the client asks about it. And if they still want to have unprotected sex once I've told them I'm HIV-positive, well, I'm not moralistic. It's not my responsibility alone whether to use condoms or not."

A. (44): "In recent years I've stopped feeling responsible for informing my sexual partners of my HIV status in advance. This is partly because my viral load is undetectable, which makes the chance of infecting others minimal."

6.4 HEPATITIS C AND OTHER STIS

At the time of the interviews, eleven of the seventeen HIV-positive respondents either had hepatitis C or had once had it (the interviews were conducted before the new hepatitis C medication became available in the Netherlands for anyone with chronic hepatitis C). Most of these men had been infected between 2006 and 2010, before most of the respondents had started having chemsex. In other words, not all of the hepatitis C infections are necessarily related to chemsex. Two respondents contracted hepatitis C again after already being cured of it once, and one respondent had been reinfected three times. Thus we counted a total of sixteen infections among the respondents. Seven of the men were still infected with hepatitis C at the time of the interviews. The remaining four had either been successfully treated or their bodies had rid themselves of the virus without medical treatment.

A. (44): "I discovered I had hepatitis C in 2008. I started receiving treatment two years later, but this had to be put on hold after four weeks because it was causing all sorts of side effects. The virus remains dormant, but I'm not bothered by it anymore."

One contributor thought his hepatitis C infection was the result of sharing cocaine snorters.

B. (60): "I got infected with hepatitis C in 2006 because I shared straws. I don't want treatment at the moment because the side effects don't fit in with my depression."

Most HIV-negative respondents were not worried about the risk of contracting hepatitis C. They believed the risk of infection to be very low on account of their HIV-negative status. The evidence so far suggests that hepatitis C is indeed more prevalent among HIV-positive MSM. However, this does not mean that HIV-negative men run no risk at all. After all, a number of cases of HIV-negative men contracting hepatitis C through sex have been identified in recent years.

B. (37): "As far as I know, there is little chance of me contracting hepatitis C. So I'm not worried about it, but it's a sensitive subject for HIV-positive men."

A lot of men are shocked when they are first diagnosed with hepatitis C. Most respondents with hepatitis C are or were always open about their hepatitis C status. But one man said he stopped disclosing his hepatitis C status after being rejected by his sexual partners for doing so. Talking

about hepatitis C is taboo in the scene, and according to some of the respondents men with hepatitis C are now regarded as men with HIV once used to be.

M. (42): "Hepatitis C is a delicate matter. It's the new HIV. Many of those who bareback are scared of contracting the virus. And it counts for nothing if your test results declare you free of hepatitis C. 'Cos who knows what you've been up to in the last two months?"

Almost all HIV-positive respondents admitted they were scared of contracting or transmitting hepatitis C. Nearly all of them said they tended to avoid having sex with men who had already been infected with hepatitis C.

K. (46): "Although I've twice been cured of hepatitis C, my sexual behaviour hasn't changed. Barebacking is still my thing. However, I am now more selective in choosing my sexual partners."

Nonetheless, some men still sometimes took the risk, for example when a steady partner contracted hepatitis C. In addition to avoiding sexual contact with men with hepatitis C, some respondents took additional measures to reduce the risk of transmission, such as not sharing sex toys and lubricants.

It is striking that many respondents think barebacking is the main risk factor regarding hepatitis C. They are not aware that it is spread primarily by blood-to-blood contact. They do not realise that after (rough and prolonged) anal penetration or fisting, blood particles containing the hepatitis C virus can end up in the pubic hair or on the forearm of the active partner, as well as in the area where the sex act took place. The virus gets transferred from one 'bottom' to another if the active partner fails to first disinfect his body parts and the area where sex is to take place. During sex parties, shower attachments (for anal rinsing) are sometimes shared by several people. This also carries the risk of hepatitis C transmission. Furthermore, few appear to be aware of the possibility of infection by different genotypes.

We know that twelve respondents regularly contracted other STIs, excluding HIV and hepatitis C; chlamydia, gonorrhoea and syphilis were often mentioned. Fifteen respondents could either no longer remember when they last contracted an STI, didn't answer this question, or deleted this information from the draft of the interview.

The risk of STI transmission was no reason for any of the respondents to refrain from barebacking. In their opinion, the risk of contracting an STI was part and parcel of their chosen lifestyle. They saw STIs as something that could easily be detected and treated. Almost all HIV-negative respondents had themselves tested several times a year for HIV and other STIs.

2 Last STI infection

Year	Number
2009	1
2010	-
2011	-
2012	4
2013	1
2014	4
2015	2
Onbekend:	15
Totaal:	27

A. (43): "I'm HIV-negative and get myself tested every three months. I'm taking part in a testing programme. I'm an SM-master, but I rarely fuck. My last STI was chlamydia."

H. (56): "I don't know my HIV status. The last time I got tested was two years ago. But as anal sex is not my thing, I don't think I'm likely to get infected. I'll take another test soon."

K. (52): "I've had unprotected sex for more than twenty years and have had myself tested every three months. I don't have HIV, but I do contract an STI every year and this hasn't changed since I began using crystal meth. I personally don't see a link between crystal meth and STIs."

Most HIV-positive respondents had themselves tested for syphilis once or twice a year during their visit to the internist. Some men were members of GGD Amsterdam's MS2 cohort, a programme in which participants were tested for all STIs four times a year. Some of the respondents apprised the men in their sex network of an STI they might be infected with after being alerted by a partner, but others didn't or no longer did so.

6.5 THE SIGNIFICANCE OF AN HIV DIAGNOSIS

Twelve of the seventeen HIV-positive men were diagnosed after 2000.

3 Year of HIV diagnosis

Year	Number
< - 1990	1
1991 - 1995	1
1996 - 2000	3
2001 - 2005	6
2006 - 2010	4
2010 - >	2
Total	17

More than half of the HIV-positive respondents did not regard their diagnosis as a big problem. Many of them had always considered it a possibility. After all they'd been engaging in sexually risky behaviour for years, so HIV was always a potential hazard.

A. (44): "I was diagnosed in early 2000. I wasn't shocked. I reacted in a very matter-of-fact way because I couldn't very well turn back time. Years of regular testing had desensitised me to the test results."

H. (54): "I contracted HIV in 2005 and it's never bothered me; I'm still not bothered. My viral load is undetectable and it hasn't caused me any problems."

B. (29): "I was diagnosed in 2010. Funnily enough my status gave me strength - the courage to live my life with more intensity. I craved adventure, including sexual adventure."

The other HIV-positive respondents did regard their diagnosis as a problem, and the news came as a shock even though they'd been aware of the risks all along. They didn't know how to handle their status in the beginning, but most of them eventually succeeded in coming to terms with it, for example by realising that this wasn't a death sentence and that they could still live to a ripe old age with HIV. A few still find it difficult to be open about their HIV status.

P. (51): "I was told I had HIV in 2009. This was terrible news; my world turned upside down. Things have settled down now, though I don't find it easy living a double life. All but a couple of friends are unaware of my HIV status."

6.6 HIV TREATMENT AND ADHERENCE TO THERAPY

At the time of the interviews, sixteen of the seventeen HIV-positive men were being treated with antiretroviral drugs. One respondent had had his treatment put on hold following an adverse reaction to his last drug combination.

Fourteen of the sixteen men taking HIV medication had an undetectable viral load. Two respondents reported that their blood levels had fluctuated slightly in recent years and that their viral load was occasionally measurable. It was difficult to tell if substance use played a role in this. Also unknown was how high the value of their measurable viral load was. A viral load can be measured but still fall below the transmissible threshold.

4 HIV medication since

Year	Number
< - 1995	-
1996 - 2000	1
2001 - 2005	5
2006 - 2010	7
2010 - >	3
No medication	1
Total	17

Most of the men said their use of crystal meth and/or other substances did not affect their adherence to therapy, with the majority taking their pills religiously. However, they sometimes took their pills earlier or later than instructed to accommodate chemsex. Some HIV-positive men took active steps to ensure their adherence wasn't compromised by chemsex. They would, for instance, set the alarm on their mobile phone so they'd know exactly when to take a break from chemsex in order to take their pills. Others had adjusted their lifestyles to fit around their pill-ingestion time, which was often in the afternoon or early in the evening. Having done so they avoided the worry of compromising their adherence on account of chemsex, because chemsex sessions usually take place in the evening, night or early in the morning.

W. (39): "I only have to take one pill a day, and that's at six o'clock in the evening. I don't typically have sex around that time, so I've never had any problems with adherence, not even when I slam."

Only a few reported occasional difficulty in adhering to therapy after using crystal meth. Those who faced this difficulty were the same individuals who had problems in other areas of life and were socially adrift. This problem is generally associated with a high frequency of use and level of dependence.

F. (30): "Now that I no longer use excessively, I'm adhering better to therapy. I found this impossible when I used daily."

SUMMARY

Condom use was low among the respondents and, according to them, similarly low within the crystal meth and slamming scene. The respondents' decision to have sex without condoms was often a conscious one and unrelated to substance use. Two of the HIV-positive men thought use of crystal meth may have been partly responsible for them contracting the infection.

Most of the respondents appeared to be aware that condom-less sex with HIV-positive men with undetectable viral loads still carried a very small risk of HIV transmission. HIV-positive respondents responding successfully to HIV treatment are sought-after sexual partners for both HIV-positive and HIV-negative men. In addition to serosorting and viral-load sorting, some men also took other risk-reduction measures.

The size of sex parties determined the extent to which HIV status and viral load were discussed. The respondents said that in small, private sex parties (with four participants on average), the level of candour about everyone's HIV status was generally high and that the participants typically inform the others in advance. The likelihood of this mutual exchange of information regarding HIV status, viral load and testing habits decreased with bigger and lengthier sex parties. At such parties, men typically arrive, join in and depart at random, with new participants finding out about ongoing parties via dating apps and websites. Consequently, any monitoring of participants' HIV status soon breaks down and discussions about HIV status are simply less likely to happen.

Fourteen of the sixteen men taking HIV medication had an undetectable viral load and claimed to adhere to their therapy. Two respondents reported that their blood levels fluctuated slightly; it was difficult to tell if substance use played a role in this. The precise value of their measurable viral load was also unknown. A viral load can be measurable, but still fall below the transmissible threshold.

Eleven of the seventeen HIV-positive respondents either had hepatitis C or had once had it. Most of these men had been infected between 2006 and 2010. Two respondents contracted hepatitis C again after already being cured of it once, and one respondent had been reinfected three times. Seven of the men were still infected with hepatitis C at the time of the interviews. The remaining four had either been successfully treated or their bodies had rid themselves of the virus without medical treatment.

Respondents were not always aware of which habits carried risks of hepatitis C transmission. Furthermore, most were unaware of the importance of disinfecting body parts, sex equipment and the area where sex took place before switching partners. Nearly all the men saw STIs as part and parcel of their lifestyle, and something that could easily be detected and treated. Almost all respondents had themselves tested for STIs two to four times a year.

7. THE BENEFITS AND DRAWBACKS OF CHEMSEX AND CRYSTAL METH



The act of sex and all the surrounding issues often throws up concerns, perhaps even more so in the case of MSM: insecurities, embarrassment, lack of confidence in sexual ability, awareness of the risks involved in sex, and society's ideas about normal and acceptable forms of sexuality. All of these play a role in sexual behaviour and the way sex is experienced. People of all sorts take one substance or the other during sex to feel more relaxed and less inhibited. For instance, many people have had sex under the influence of alcohol. The gay scene is no different; however, the substances involved tend to be.

As previously mentioned, chemsex in general, and the use of crystal meth in particular, appear to be growing phenomena within certain subgroups of the MSM population. But what is driving this popularity? What sexual, social and psychological functions does substance use fulfil for MSM? An initial response to these complex questions is outlined on the basis of the interviews with respondents (Sections 7.1 and 7.2). The state of intoxication produced by chemsex, especially when it involves crystal meth, is not without side effects (Section 7.3), which are often experienced as unfavourable. These, however, are often outweighed by the advantages of the favourable effects of drug use.

7.1 THE APPEAL OF CHEMSEX

Sex under the influence of drugs is perceived as exciting, overwhelming, incredibly arousing and liberating. One can go on for longer because the drug delays one's orgasm;

meanwhile your erection is maintained with the help of erectile-dysfunction drugs. The eventual orgasm is experienced as so much more intense. All respondents reported experiencing more sexual freedom on account of the drug's ability to minimise feelings of embarrassment and insecurity about sexual performance and attractiveness. It makes them feel more self-confident and attractive, hornier, more powerful, more energetic and euphoric. Others, referring to the context of chemsex, mentioned expanding their sexual boundaries and engaging in sexual exploration. The next section elaborates on these perceived benefits.

P. (51): "Everything fell into place after the divorce, and I set about defining my life as a gay man. I met my first sex contacts in gay saunas, bars and clubs. The first time I scored a chemsex date online, all my inhibitions fell away. At last, I could have carefree sex."

Almost all of the respondents had already had sex under the influence of substances such as GHB, cocaine, MDMA and ketamine before trying crystal meth. These first experiences made them curious to experiment more with chemsex. People are usually unaware of the full effects of crystal meth when they first come into contact with it, and all respondents said their first experience with it was overwhelming, and, according to many, intense in a way that no other drug could match.

B. (60): "I'll never forget my first experience with tina. A sexual partner offered it to me, and I had no idea what to expect. Wow! The feeling is indescribable. It's so intensely hot that you soon crave another hit. That desire stays in your memory, and you never, ever forget it."

Some use crystal meth once and leave it at that, but many of the respondents continued taking it, seeing it as the ultimate drug for fulfilling certain needs. It would be easy but erroneous to put the entire appeal of chemsex down to the effect of drugs such as crystal meth. Aside from the feelings induced by drugs, psychosocial factors also play a role in attracting men to chemsex. For example, a number of respondents cited the need for human connection as a major factor in engaging in chemsex. They get to meet likeminded people through chemsex, which erases their sense of isolation and satisfies their deep need for belonging. For various reasons, some respondents had struggled to find connection within the gay scene, form new friendships or find a partner. They often led busy lives with many responsibilities and seem to have had difficulty entering into intimate relationships. Even things like coming out at a relatively late age or living in parts of the country where the gay scene is relatively small play a role in causing men to gravitate towards chemsex. Before discovering chemsex, people in these circumstances rarely met few other gay men .

The feeling of being different from others frequently arouses feelings of loneliness and social isolation. These feelings evaporate when one participates in a chemsex session and experiences the effects of crystal meth - even if the evaporation of those feelings is only temporary. Some men report feeling a bond with the other participants in the run-up to a sex party. The fact that outsiders perceive their specific sexual practices and manner of drug use as overstepping boundaries of acceptable behaviour merely reinforces this sense of belonging.

Many respondents said they sought aspects of belonging, intimacy and friendship within their sex network that they could not find outside it. They came into contact with other men via dating sites and apps for MSM, and it was with these men that they were able to fulfil their needs in practice. This might involve chemsex, but it could also take the form of friendly contact with likeminded people. Intimate issues such as substance use, sexual experience, HIV and (to a lesser extent) hepatitis C can be discussed openly and honestly within the sex networks. It's often difficult to discuss such topics with family members or non-gay friends, and they usually conceal their interest in these matters out of shame and the understanding that society considers the issues taboo.

A. (43): "Whenever I feel like trying a new substance, I always do so with a trusted mate. Thus we experience the effects together. But that doesn't mean we also have sex. Sometimes we just chit-chat endlessly; other times we might watch porn."

Many respondents claim to experience a sense of connection and community from being in the meth/slamming scene. Although many of them mentioned a degree of superficiality and egocentrism in the scene, they also indicated that communal drug use and a common sexual interest gave them a feeling of connectedness and sense of belonging. That might explain why some respondents talk about strict social norms within those subgroups of the gay scene in which drug use and condomless sex is a given. Some men experience this norm as pressure to conform (peer pressure).

S. (40): "Everyone is wired on chems at the bigger parties. You almost get the feeling you need to explain yourself if you're not using. The same applies whenever I try to arrange a date online. The very first question is always: 'What chems do you take?' It's almost as if no one is fucking without chems."

7.2 THE BENEFITS OF CRYSTAL METH

Why is crystal meth the ultimate chemsex drug for so many? More than three-quarters of respondents found the effects of crystal meth more appealing, more intense and a better fit for their needs relative to other drugs. For many respondents, the most significant benefits offered by this drug in comparison to all others is the unparalleled level of euphoria and loss of inhibition it offered them, combined with the energy and sexual arousal it generates during chemsex. These benefits can be divided into three categories:

- it helps to expand boundaries
- it helps to overcome uncertainty, anxiety and worries
- it enhances the sexual experience and improves sexual performance

EXPANDING THE BOUNDARIES

The crystal meth experience of almost all respondents was one of ultimate sexual liberation, a degree of freedom they had never felt before. Most of the men said crystal meth set them on a journey of discovery of new sexual techniques and across sexual borders. Three-quarters of respondents said that when they were under the influence of crystal meth they preferred having sex with several men at once. They also said they found it more immediately appealing and easier to try things like BDSM, fistfucking, ass play, golden showers, electro and bondage, activities they wouldn't otherwise dare consider and/or be able to engage in. But with crystal meth they can live out all their fantasies shamelessly, fearlessly and without resistance.

B. (32): "I'm usually able to maintain a semblance of self-control when I use other drugs, but not with crystal meth. You can take things so much further sexually. Even fistfucking, which I was never into, is a fantastic experience when you're on tina."

In addition to trying new types and techniques of sex, some of the men also said they found it easier to switch sexual roles when they were on crystal meth. The sexual roles preferred by the respondents during chemsex varied (see table). Two men always chose the passive role (bottom). Nine men were usually passive but sometimes active (bottom / top). Seven respondents switched between roles during chemsex sessions (versatile). Six men were usually active, but sometimes passive (top / bottom) and three men were only ever active (top).

M. (42): "I remember that I was on the floor when the rush hit me. I felt like being fucked by a stallion, whereas I'm not usually a 'bottom'."

1 Sexual role	
Preference	Number
Bottom	2
Bottom/Top	9
Versatile	7
Top/Bottom	6
Top	3
Total	27

OVERCOMING UNCERTAINTY, ANXIETY AND WORRY

More than half of the respondents felt more confident, stronger, superior and invincible when on crystal meth. It gave them a feeling of indomitable power. All the insecurities, fears and worries that usually encroached on the sexual experience and hampered sexual performance simply faded away. As a result, the men had fewer inhibitions and were better able to be in the moment and enjoy the sex a lot more.

B. (47): "Tina equals freedom. No worries about condoms, HIV status or hepatitis C, and freedom from past sexual mishaps."

Many respondents admitted to a low level of self-esteem and insecurity about their appearance and sexual performance, preferences and desires. But they said their self-image improves and their self-esteem rises when they're on crystal meth. Men who usually feel insecure and/or inexperienced when they have sex sober, feel (and receive confirmation that they're) awesome, potent, strong and unsurpassable when they're on crystal meth.

A. (44): "All manner of sexual blockages, inhibition or insecurities vanish under the influence of crystal meth. The drug unleashes the beast within. I feel smoking hot and attractive, and receive tenfold confirmation of my sexual image, which gives me even more confidence."

Acceptance of sexual orientation, either by society, close ones or oneself, is often an issue. Approximately one-third of respondents had experienced some rejection during their youth on account of their homosexuality, by others in their immediate environment sometimes by themselves in the form of self-hatred. Some of the respondents only came out of the closet in their thirties or forties. But while taking crystal meth and participating in the chemsex scene, all their concealed and painful feelings caused by rejection, intolerance and homophobia vanish. They say they feel more accepted as gay men within their sex networks and/or are better able to accept and embrace their own homosexuality.

M. (23): "My coming out was hard; the people close to me were shocked. My parents sent me for therapy, but of course that was a waste of time. I fled to Amsterdam six months later, and used crystal meth for the first time a few months after I arrived. Having sex on crystal meth was an amazing and liberating experience; the most beautiful thing I'd ever experienced."

The phenomena of HIV, hepatitis C and STIs have an influence on how sex is experienced. All respondents preferred barebacking and did not typically use condoms when having sex. And although this was usually a conscious choice, it doesn't mean the decision is free of conflicting emotions. The social norm of using condoms sometimes makes it difficult to bareback without guilt. Stigmatisation or rejection on account of HIV and/or hepatitis C is common. Despite freely choosing to bareback, many respondents were concerned about contracting or transmitting HIV, hepatitis C and/or other STIs. But all these concerns melt like snow in the midday sun when they take crystal meth.

T. (44): "I worry constantly about the risk of infecting my regular partner with hepatitis C. We always bareback. But I'm always careful and vigilant about cuts. If I spot blood during sex, we stop immediately."

THE PHYSICAL BENEFITS

The respondents were highly appreciative of the many physical benefits of crystal meth. They all claimed it gave them so much energy that they felt like having sex for longer, much longer than they could with other substances. Chemsex involving crystal sometimes went on for days, with the men losing all sense of time, yet without experiencing physical exhaustion, loss of concentration or the need for sleep.

Many men find their sexual experiences improved by the sense of euphoria combined with the considerable sexual arousal generated by the drug. Sexual sensitivity to touch and the perception of smells and colours, for instance, are enormously heightened. Ejaculation is often delayed for a markedly long time. When one finally climaxes, the orgasm is usually more prolonged and much more intense.

H. (54): "Crystal meth's sexual effect usually proceeds in stages. First, you feel a massive wave of heat, followed by tingling in your hands, feet and head, and finally your genitals and anus start to glow. The blissful feeling, extreme horniness, the enhanced sensitivity of the skin. All sense of time dissolves."

2 Benefits of crystal meth

(multiple answers possible)

Benefits	Number
Longer-lasting sex	22
Loss of inhibition (sexual and otherwise)	21
More energy	20
Group sex	19
Barebacking	19
Increased self-confidence	17
Increased sexual energy	17
More extreme sex	16
Prolonged orgasms	15
Temporary shedding of HIV/hcv status	14
More intense orgasms	14
More powerful ego	8

7.3 THE ADVERSE EFFECTS OF CRYSTAL METH AND SLAMMING

As is the case with all drugs, crystal meth also has unpleasant or undesired effects. This is also true regarding the slamming route of administration. Almost all respondents had experienced adverse effects from taking crystal meth or slamming during chemsex. This section describes the adverse and/or undesired effects mentioned by respondents who have experienced them on account of using crystal meth and/or slamming. The long-term adverse effects are addressed in *Chapter 8*.

OVERDOSING

More than half of the respondents have experienced one or more physical problems and/or passed out on account of taking an overdose. This phenomenon is not always due to crystal meth; it can also be caused by taking other substances, alone or in combination. Ketamine or the combinations of crystal meth and GHB/GBL or mephedrone were the most often cited substances in connection with passing out. Two of the respondents had had to be admitted to hospital after overdosing on crystal meth.

MENTAL-HEALTH PROBLEMS AND PSYCHOTIC SYMPTOMS

Almost a third of the respondents said they'd suffered mental-health problems and/or experienced psychotic symptoms while under the influence. They cited paranoid thoughts, delusions, hallucinations, anxiety and panic attacks, near-death experiences, disorientation,

aggression, hostility and violent behaviour. One or two of the respondents experienced this not during chemsex, but when they'd been out with friends or at a club. Respondents reported these symptoms often in regard to sole or combined use of substances like LSD, ketamine, GHB and GBL, and in relation to having taken (a high dose of) crystal meth. These symptoms were most often reported by the respondents that regularly went for two or more days without sleep or periods of rest while on crystal meth.

B. (42): "I sometimes went on non-stop for an entire day until my system could take no more and I was completely off my face - then I'd pass out like a light. And when I took lots every day, I often felt paranoid, and would start hearing imaginary sounds and voices."

CRAVING

More than three-quarters of the respondents who used crystal meth had a strong desire to take more of it when they felt its effects starting to wear off, both during sex sessions and during the coming down phase (see *Chapter 8*). They stated that the craving or greediness generated by crystal meth is much stronger than that of other substances. Although post-sex craving was mentioned most often, it also occurred during sex sessions. In the latter case, respondents claimed this often meant they found themselves engaging in sex for much longer than they could handle or had planned, but it was hard to stop once they'd started.

B. (32): "Tina makes you incredibly greedy. You just crave more and more, and everything starts to revolve around sex and tina. You keep going at a furious pace, often for longer than planned."

UNDESIRED SEXUAL EXPERIENCE

Five respondents had occasionally experienced the boundary-expanding effect of chemsex as unfavourable, having engaged in sex acts that they later regretted. Three of them had no memory of what sexual practices took place after they'd passed out from taking too much ketamine, GHB or GBL during chemsex. Four of the men felt guilty or ashamed after engaging in sexual activity that overstepped their boundaries while under the influence of crystal meth.

C. (49): "My sexual partner passed me some ketamine orally during a big sex party. It tasted horrible. I'd already taken some GHB, so I passed out shortly thereafter. When I came to about two hours later, I realised I'd been fisted while lying in a coma. I only allow myself to be fisted when I'm in a sling. It was a bizarre experience and I still feel uneasy about it."

M. (23): "During one sex session that went on for days my sexual partner suddenly suggested we share each other's blood. I was now so off my face that I agreed. It was just another step in the uncharted territory of using crystal meth. But I now regret it greatly"

ERECTION PROBLEMS

More than half of the respondents had suffered erectile dysfunction on account of taking crystal meth. The majority of respondents always took erectile-dysfunction drugs during chemsex. Some of the men did not see this side effect as a problem. Chemsex for this latter group had more to do with 'boundless horniness' than the need or necessity to climax. Erectile dysfunction was also reported on account of taking cocaine, 4-MEC, mephedrone and 3-MMC.

A. (44): "Whenever I use tina, I take Kamagra, too. I can't get erect otherwise. Erectile-dysfunction drugs also neutralise my sexual blockages."

CHANGES IN THE WAY SEX IS EXPERIENCED

After prolonged crystal meth use, some of the respondents lose interest in sex with other people. The focus becomes increasingly geared towards taking the drug and less and less towards making sex-related contact. Sexual activity is gradually reduced to activities like chatting online, webcam sex, watching slamming and porn clips, and extended masturbation sessions. More than half the men had difficulty getting sexually aroused or experienced no sexual arousal at all if they hadn't taken one drug or the other. Sober sex became impossible or simply uninteresting.

M. (42): "Slamming was delivering less and less intensity. At one sex party, I found myself on the sofa with the other men watching porn when we should have been fucking."

SELFISHNESS

According to a small number of respondents, crystal meth makes you sexually selfish. You become focussed solely on your own sexual desires, fantasies and gratification, which kills the sexual dynamics between partners.

A. (44): "The biggest disadvantage of crystal meth is the selfishness it brings out in some men. If they don't get what they want during a sex session, they'll sometimes start Whatsapping right there and then. Everyone becomes so fixated on acting out their own fantasies that the ideal of equitable giving and taking is completely forgotten."

COMING DOWN

All respondents experienced the adverse after-effects of crystal meth, both physically and mentally. This is known as 'coming down'. Some respondents undergo this phase stoically, regarding it as 'the logical consequence of use.' The physical and mental problems experienced while coming down are further discussed in *Chapter 8*.

DRY OR CRACKED LIPS

Some respondents suffer dry and/or damaged lips during or after smoking crystal meth. This is caused by the dehydrating effect of crystal meth on the system, as well as by the meth pipe, which can get very hot during use. When the lips become dry, they crack, and sometimes bleed. Most men who smoke crystal meth share meth pipes with their sexual partners. Others are very strict and principled about using only their own smoking tools. Only a few respondents were aware that pipe sharing increased the risk of hepatitis C transmission.

C. (43): "I usually forget to drink enough water and often develop scabs on my lips due to the extreme dehydration caused by crystal meth."

DAMAGED VEINS

Slamming techniques within the crystal meth/slamming scene leave much to be desired. Not everyone has learned how best to slam without causing unnecessary damage. Incorrect slamming technique can cause vein damage or even render them unusable. The fear of sporting noticeable track marks leads some respondents to avoid injecting themselves in the arms, choosing instead the legs and/or feet. But the veins in the legs and feet contain more valves and are smaller and more vulnerable to damage. Consequently, slamming into these parts of the body can be very painful and raises the likelihood of vein damage. Two of the respondents slammed into the neck or groin out of necessity. Their (almost) daily use over a long period had rendered their other veins unsuitable. Slamming into the groin and neck is not without risk, as the veins, arteries and nerves in these areas are within close proximity to one another.

T. (44): "I'm forced to keep finding new veins on account of my daily use. I started out slamming into my forearms and upper arms. Then I moved to the hands, feet and legs and finally the neck and groin."

BRUISES AND ABSCESSSES

More than half of the respondents who slammed, occasionally developed bruises on or around the point of insertion on account of poor slamming technique or from reusing needles. Abscesses can develop when slamming is not sterile. Five respondents had had an abscess.

B. (37): "People often reuse needles, but the risk of bruising increases because the needle becomes blunter. I've often had that."

H. (54): "I once had an abscess the size of an egg. Hugely swollen and bright red. This was probably because the water in which I'd dissolved the chems wasn't sterile. The swelling decreased after a week on antibiotics, but I suffered for weeks."

SUMMARY

The interviewees cited a number of sexual and psychological effects that crystal meth has on sex. It helps them to overcome insecurity, fear and anxiety and enhances their sexual experience and performance. In addition, it helps them expand their sexual boundaries.

Chemsex also appears to serve a social function: it gives the men a sense of 'belonging' and community.

Respondents cited the adverse effects of using crystal meth and slamming drugs, such as dry and/or cracked lips, erectile dysfunction and loss of libido. Slammers mentioned bruises, abscesses and damaged veins.

Some respondents said that crystal meth makes users sexually selfish. People start to focus solely on their own sexual desires, fantasies and gratification, which kills the sexual dynamics between partners.

More than half of the respondents had experienced one or more physical problems and/or passed out from an overdose.

Almost three-quarters of the respondents experienced a strong craving for more crystal meth when they felt its effects starting to wear off during sex sessions or while coming down.

Almost a third of the respondents said they'd suffered mental-health problems and/or experienced psychotic symptoms while under the influence.

8. THE EFFECT OF CRYSTAL METH AND SLAMMING ON THE INDIVIDUAL'S PHYSICAL AND MENTAL CONDITION AND ON THEIR ABILITY TO FUNCTION IN SOCIETY

All respondents reported experiencing both the significant physical and psychological impact of crystal meth and/or slamming. They experienced physical (Section 8.1) and psychological (Section 8.2) problems particularly during the coming-down phase. Some respondents undergo this phase stoically, regarding it as the unavoidable consequence of the conscious choice to take crystal meth during chemsex.

Ten respondents had experienced one or more periods of psychological dependence on crystal meth since they'd started using the drug (Section 8.3). They'd also experienced its impact on their ability to function in society (Section 8.4).

Section 8.5 discusses the measures respondents take to minimise the risks and adverse effects of using crystal meth and/or slamming and keep their level of use under control.

8.1 PHYSICAL PROBLEMS

The longer sex under the influence is performed, the more severe the physical symptoms and the longer it takes to recover. The amount used, the combination of substances and the route of administration all play an important role in this regard. According to the majority of respondents, coming down is more severe when crystal meth is slammed than when it is smoked. They generally found the first two days of coming down the most difficult to bear. The following is an overview of the most frequently mentioned

problems experienced when coming down after chemsex sessions involving crystal meth and/or slamming.

SLEEP DEPRIVATION

The respondents' chemsex sessions typically went on for a minimum of twelve to fourteen hours. Some respondents said they had self-imposed restrictions and kept it to about half a day. More than half of the respondents reported carrying on for longer, and in such cases the sessions went on for an entire day, the whole weekend or even sometimes for up to four days. Most respondents found it impossible to take a nap or a short break during chemsex sessions because the drug inhibited or delayed the need for sleep. All respondents cited this lack of respite and sleep deprivation as the biggest drawback of crystal meth. They suffered extreme fatigue and general physical exhaustion during the coming down phase.

A. (43): "Notwithstanding my energy and clear focus the day after such a weekend, I often fall asleep for a long time in the afternoon. It typically feels like I've run a marathon. I usually sleep for at least 12 hours that first night, but often longer. Longer still the subsequent nights, and the sleep is remarkably deep, too. If I have to work that week, then I'll sometimes go to bed as early as six o'clock in the evening every day."

N. (53): "I'm usually pretty exhausted after a slamming party and catch up on sleep afterwards. It takes me at least nine days to feel physically fit again, and it takes my partner up to seven days."

The amount of time needed to restore natural sleeping patterns and feel somewhat energised again after a chemsex session varied. Respondents who took part in shorter sessions (twelve to fourteen hours) experienced less disruption in their sleeping pattern and were less depleted in the days afterwards. But the men who carried on for a full weekend or longer reported needing three to seven days to refuel. Seven respondents said that when planning a sex session, they factored in sufficient time to relax and get enough sleep during the coming down phase. Many respondents took sedatives after chemsex. A few took a dose of GHB, GBL or ketamine after sex sessions to help them sleep.

A. (44): "If I carry on for two or three days, then sleeping pills are the only way I can get to sleep. I sleep for no less than six hours that first night, and at least fourteen hours the night afterwards. So I need a minimum of six days to regain my normal sleep rhythm."

M. (30): "I often find it difficult to sleep after carrying on for days. What I then do is slam a dose of GBL subcutaneously into my butt so I can at least catch a few hours of rest."

FLUID DEPLETION AND NUTRITIONAL DEFICIENCY

For many, food intake is difficult to impossible when taking crystal meth. This applies to a lesser extent to the slamming of other substances. As a result, many of the respondents said their energy levels were greatly reduced and that they felt empty while coming down. Many also said they felt physically weak after chemsex. Some of the men took food supplements immediately after sex dates to promote recovery. The ones who often participated in prolonged chemsex sessions suffered a loss of appetite (for food) during the coming down phase. They were only able to consume reasonable quantities of food again after a couple of days.

A. (44): "I sometimes spent the whole day in front of my computer without a break or having anything to eat. It was only when I stopped using that I'd realise how much I'd depleted my reserves."

B. (60): "I always feel sluggish and empty after a slamming session on account of not eating enough. I can usually only eat small amounts for the first couple of days after using. I do take vitamins and lots of glucose, though. Or I take an effervescent ORS [oral rehydration solution] tablet to compensate for the shortage of salts and minerals. And then I start eating everything I can get my hands on, from sweet to sour. After all, the body has just had a shock."

Crystal meth suppresses not only appetite, but also thirst. It raises the body temperature, so users sweat a lot more than usual. Respondents also said they forgot to drink because they were so focussed on sex, and that they

sweated a lot on account of their sexual activity. These factors in combination can quickly lead to dehydration.

A. (43): "I've often seen sexual partners not drinking enough and becoming completely dehydrated after a day. When that happens, you can pinch their skin between your fingers and the gathered skin will remain upright."

F. (30): "I was often so focused on sex that I forgot to drink. Then your sweat becomes pungent. I'd sometimes lose a few kilos during a weekend session."

DENTAL PROBLEMS

Six respondents had dental problems as a consequence of taking lots of crystal meth, and taking it often. Crystal meth increases the tension in the jaw muscles. This can instigate teeth grinding, which may eventually result in tooth damage. Respondents also report extreme dryness in the mouth due to the cessation of saliva production. Respondents rarely brushed their teeth during or shortly after chemsex sessions. This, in combination with a lack of saliva, promotes the growth of bacteria in the mouth, which can eventually lead to cavities, gum inflammation and tooth loss. Only four respondents said they took good care of their teeth after chemsex. Others took little or no time for this on account of physical exhaustion.

B. (42): "I was sometimes so wired for days [while using] that afterwards I had muscle pain all over my body. Even my facial muscles, teeth and jaw ached from the constant tooth grinding."

M. (23): "I'm really happy my teeth are still okay. Crystal makes you grind your teeth excessively and dries out your mouth. One of my regular sex buddies recently lost two front teeth."

OTHER PROBLEMS

Besides these above-mentioned consequences of successive days of using without sufficient food, water and rest, taking crystal meth can also have other adverse effects. Some of the men cited problems such as itching, twitching muscles, nausea, vomiting, diarrhoea, heart palpitations and shortness of breath. Not all respondents were asked about these specific problems during the interviews.

F. (30): "I often itched all over after using. It sometimes took a great deal of effort not to scratch myself until I bled."

T. (44): "Slamming or booty bumping tina gives you a great rush, but it left me sick for almost two weeks afterwards. I experienced all kinds of discomfort as a result of using for successive days, such as deep depression, fever, heart palpitations, abdominal pain and diarrhoea."

8.2. MENTAL HEALTH PROBLEMS

Crystal meth use appears to be related to reduced mental wellbeing in both the short and long term. Coming down is often psychologically severe, although this varies greatly from person to person. The rate of mental recovery is often dependent on the duration of the sex session, the route of administration and amount of crystal meth consumed, and on the combination of substances used when drugs are combined. It is also dependent on what the men do following a period of use, and if they get sufficient rest, nutrition and hydration. The respondents who plan long intervals between sex dates tend to feel more psychologically stable than those that use more often or continuously.

Having a job or other (social) activities appears to be a protective factor. The respondents with many daily distractions experienced fewer symptoms than men with less demanding daily schedules. This latter group of men used a lot and often, and suffered from dependence, which might explain their susceptibility to short- and long-term mental health problems.

The longer the men used crystal meth, the more negatively they described their emotional life. More than a third of respondents were long-time crystal meth users. Some of these men said they found it increasingly difficult to remain optimistic about life. A few described a vicious cycle of use, coming down, depression, craving and reuse, with this spiral heading increasingly downwards. They were also losing their ability to function in society, a phenomenon discussed further in Section 8.4.

P. (51): "I have slammed tina four times and the experience was amazing. But I was totally shaken up and extremely depressed in the days that followed. I sometimes tell people: 'Tina means two days in heaven followed by three days in hell.' I daren't do it anymore. My work is sacred to me and tina could jeopardise it; I don't want that to happen."

More than three-quarters of the respondents suffered from depression, mood swings and irritability during the coming down phase. They felt empty, down, extremely sluggish and often had a poor to very poor self-image during the period. Some of the men said they suffered long-term concentration problems and nervousness, and that they sometimes responded agitatedly and aggressively to those around them. Some respondents worried a lot about their use and/or felt guilty about using. A few had had suicidal thoughts for short or longer periods during the coming down phase.

The men who slammed crystal meth or other substances experienced symptoms of depression more often than those who smoked. Some respondents stated explicitly that poly-using ecstasy, MDMA, cocaine, mephedrone, 4-MEC and 4-FA also caused depression and mood swings during the coming down phase.

PSYCHOTIC SYMPTOMS

Six respondents had experienced psychotic symptoms while using. They attributed this to their drug use and successive days of sleep deprivation. In particular, they mentioned paranoid thoughts, delusions, hallucinations, anxiety and panic attacks and disorientation. The severity of these disorders usually diminished naturally as the men recovered.

Two respondents who had used crystal meth several times a week for a long time and did not get enough rest between sex dates experienced the psychotic symptoms for longer, sometimes for up to two days. Three respondents had been admitted to hospital for observation on account of psychotic symptoms.

L. (35): "I was chilling in the bath twelve hours after four days of non-stop use when I was suddenly overcome with paranoid delusions - really major panic attacks. I was even afraid of my cat, and I eventually ran out onto the street. The police later turned up to help but I apparently reacted quite aggressively. Eventually, they called an ambulance and I was taken to hospital. But even there I thought the hospital workers were part of a sinister plot to kill me. Horrible experience. I had carried on for too long and had taken too much tina."

CRAVING

Nearly one-quarter of the respondents said that the need to take crystal meth or slam evaporates after a sex date and that they experience little or no post-date craving. However, more than three-quarters said they developed an intense craving to use again after taking crystal meth. According to the majority, the craving generated by crystal meth is much more intense than that generated by other substances. The craving is felt most intensely during the coming down phase and may resurface long after this period. Half of the men said they had enough self-control to resist this craving. They connect using exclusively to sex. Some were also less affected by craving because of their ability to shift their focus back to their daily activities. However, the other half found it (almost) impossible not to use when they had the drug at home. The craving would sometimes be so intense that they would continue using despite complete physical exhaustion. They recognised and acknowledged their current or past dependence on crystal meth.

R. (59): "I believe that self-control with respect to slamming is connected to conscious use. The key question here is: why do you use? If you slam to mute or mitigate problems, then you're more likely to become addicted. I use crystal meth to enter a bubble of experience. In this bubble I'm completely detached from everything for a short while, and can, in this world of mine, engage in prolonged sex. And when I'm done with the sex, the need and craving fades."

8.3 DEPENDENCE

Ten respondents used or had used excessively for short or prolonged periods of time. They considered themselves psychologically dependent, viewed their use of substances during sex as a downward spiral, and derived less and less vitality, satisfaction and inspiration from using. Six of them said they were or had been dependent on slamming crystal meth. Two smoked crystal meth on a daily basis and two had slammed 4-FA or 3-MMC. Four of these men said they were also addicted to sex, and considered this the driving force behind their substance use – they could no longer have sober sex. Six men considered themselves primarily dependent on crystal meth, and their need for sex with other people had been diminishing steadily. Using had increasingly occupied centre stage, pushing the sexual component more and more to the periphery. Four of the men (the so-called ‘needle freaks’) considered slamming itself to be the great attraction, sometimes even more so than the substance being slammed or the chemsex.

M. (23): “Once I started slamming at home, I began using more often and kept upping my dosage. My flatmate was worried, but I hid the syringes and slamming gear. Meanwhile, I was quietly and completely losing the plot. The drugs were no longer having the desired effect, no matter which drug I slammed, and I’ve slammed all available water-soluble drugs.”

T. (44): “I lost control when I started slamming. I overstepped my structural boundaries and fell further and further. I began to use in ever greater quantities, sometimes taking two shots in succession, sometimes even two at a time. And I was doing so increasingly on my own and at home. I was hardly feeling the rush anymore. I just craved ever larger amounts of chems. The kick you derive from the successful insertion of the needle, seeing the blood in the syringe, and then the rush.”

Daily use among the respondents who considered themselves psychologically dependent had increased incrementally until it became excessive. As this happened, the eight that slammed did so less and less safely. More than half of the excessive users described their habit as escapism, and as a way to cope with everyday problems and stress. All respondents knew men both inside and outside their sex networks who were heavily drug dependent. Nearly half knew someone who had committed suicide during a period of dependency and excessive use.

B. (42): “The basis for my addiction was something I felt physically. The very idea of ringing my dealer would kick-start a deep yearning and my body would already begin to anticipate the drug. My need to use was primarily connected to freeing myself from everyday concerns and work-related stress. You see, my mind emptied itself completely once I was under the influence. But once back on Earth, the stress returned with twice the intensity. Then the temptation to smoke again was great.”

T. (44): “I went cold turkey earlier this year and have been clean ever since. And though I find life hard going, I now see slamming as a form of escapism. I’m on antidepressants, but still think about slamming every day, especially when others talk about it or when I watch a slamming clip on my Tumblr page. My body is still recovering from the damage to my veins. It’s a painful recovery, and I sometimes develop itchy spots on the broken veins.”

The duration of excessive use varied from a few months to three years. Many had tried to quit, but few managed to avoid using again. The most common pitfall causing people to relapse was the difficulty of achieving intimacy without drugs. These men were reluctant to have sober sex because without drugs they didn’t feel attractive, lacked self-confidence, etc. A few said they would not be able to get intimate with anyone or have a relationship for quite a while. Other frequently mentioned pitfalls were the normal daily activities that often aroused their craving quite unexpectedly. These included browsing and chatting online, their circle of friends, socialising, or even just having a conversation. Six men considered themselves dependent for life. Almost all respondents found it very hard to delete their online and app dating profiles, afraid it would leave a great void. And ceasing to engage in chemsex would mean the loss of a considerable number of their social contacts. When they did go online, they found the experience risky and difficult.

F. (30): “I’m dreading sober sex becoming the new norm. The very idea makes me nervous and restless. How will I still be able to consider myself sexually attractive? I sometimes think I’ll never be able to manage it. That’s why I only had chemsex for so long. Well, sex without drugs it’ll have to be. But I really can’t imagine it.”

M. (23): “I became addicted to the needle rather than the chems. The ritual of slamming was my trigger. Just thinking about it makes me horny. I happened to see a picture of a syringe yesterday. It sparked something in me, causing a restless and unsettled feeling in my stomach. A moment of intense craving.”

S. (40): “I’ve been clean now for three and a half months. And yet I have moments every week when I find myself chatting online. Very risky. And that’s my pitfall. I sometimes chat with men who are still having chemsex, which ultimately leave me with a dry horniness. When this happens I break off the chat, but only with great difficulty, lumbering myself with a strong craving along with enormous feelings of self-recrimination and guilt. But I’m not ready to delete my dating profiles for good.”

8.4 THE IMPACT ON ABILITY TO FUNCTION IN SOCIETY

The men who use for a prolonged period of time struggle with a variety of psychological problems that influence their ability to function socially and in society. As already mentioned, ten respondents indicated that they had lost control of their habit at least once. Most of them stated that those around them were not or rarely aware of the extent and severity of their habit. Two of them had or had had a relationship during their period of long-term use while the others were or had been single. Six of the men had lost contact with family and friends at their lowest point of dependency. They had become socially isolated, which made them feel lonely and lowered their self-esteem.

M. (23): "In the end I was taking so much 3-MMC every day that other substances became unaffordable. I shut myself away in my room or went to sex parties. I had hardly any friends and my sole focus was on my habit. But I became increasingly depressed, had suicidal thoughts and found myself completely lost."

These men find it very difficult to survive in society and to keep up with regular activities such as working or studying. Seven of the men worked less, lost their jobs or started claiming sickness benefits during their period of excessive use. With one in seven, substance use becomes uncontrollable during a burnout. One respondent lost both his job and his house during a period of dependency. The other two respondents were managing to fulfil their work and social obligations, but it took a lot of effort and energy for them to do so.

S. (40): "I sometimes carried on for too long and didn't make enough time to come down. Then I'd find myself off my face at work, and if someone made a remark about my bloodshot eyes I'd explain it away as a cold or hay fever. I felt guilty about that later."

M. (42): "I lost interest in everything because of tina: what was happening in society, my everyday responsibilities, my social responsibilities, etc. I was constantly preoccupied with using and slamming. My relationship was on the verge of imploding and my work suffered. I no longer cared about all the things I once loved."

All the respondents knew men in their sex network that were preoccupied entirely with their crystal meth habit, whether in conjunction with sex or not. And they'd seen them lose their grip on their ability to function socially and in society on account of their habit.

8.5 SELF-REGULATION AND HARM REDUCTION

Seven respondents strongly believed that trying to exercise self-control with respect to a crystal meth habit or slamming in whatever form is impossible. Three-quarters of the respondents said they used different tricks and strategies to control their level of use to the greatest extent possible

and limit the potential health damage to themselves and/or their sexual partners. But the implementation of these strategies often became sloppier the more excessive their drug use. They stopped using things like alcohol swabs, tourniquets and disinfectant cream. They slammed too often into the same spot or reused needles, and engaged more readily in sexually risky behaviour.

The men had all sorts of self-regulation and harm-reduction strategies for controlling their use of crystal meth and/or the extent to which they slammed during chemsex. The following is an overview of the most frequently mentioned strategies.*

STICKING TO A REGULAR SEX NETWORK

One-quarter of respondents restricted their sex network to a small group of regular sexual partners with whom they built a relationship based on trust. It was typical within these networks to discuss beforehand what and how much of a substance would be taken during chemsex and members were open about infectious diseases.

K. (46): "I don't slam with just anybody. I need to trust you before we use together. That's why I limit my activity to a small group of men with whom I've subsequently also built a friendship outside of chemsex. They always alert me if any member contracts an STI."

TIME PLANNING

Five respondents always put a time limit on their sex dates and discussed this in advance with the sexual partners. This time limit (usually twelve hours) was rarely exceeded and had the advantage of moderating usage, which mitigated coming down. One-third of the respondents scheduled chemsex sessions at the start of the weekend to allow plenty of recovery time before the workweek began.

SETTING

Twelve respondents only used during chemsex. Half of the respondents only had chemsex in environments they were already familiar with: at home or at the homes of regular sexual partners. They would never consider using in some other more anonymous setting and they never went to open, anonymous chemsex parties. This was how they minimised the health risks.

B. (37): "I only use at weekends and always at home. That way I can keep track of what's going on and manage the situation if someone attempts to overstep my boundaries."

* We can not vouch for the effectiveness of these strategies.

FREQUENCY OF USE

Five respondents deliberately scheduled two- or three-monthly chemsex sessions or only a few sessions each year. This allowed them to exercise self-control and derive maximum enjoyment from chemsex when it happened. A quarter of respondents regularly alternated the substances they used and/or slammed. They believed this would help minimise the risk of becoming dependent on any one drug.

B. (32): "I now use twice a year. I plan my weekend of using well in advance and make sure I have enough time and space to recover the week after. That's how you maintain the impact and effect of using."

QUANTITY OF CONSUMPTION

A quarter of respondents adhered strictly to a maximum dose per occasion and rarely or never combined crystal meth with other substances. They discussed this with their sexual partners before the session began. They also paid attention to the time of intake and avoided taking another dose while the first dose was still in effect.

R. (59): "Tina's duration of effect is eight hours when slammed. I abide strictly by that before slamming again. But I often see guys slamming in quick succession, taking a second dose too soon after the first. This only increases the risk of overdosing and drug-induced psychosis."

COMBINATION USE

All but two of the respondents did not drink alcohol before or during chemsex sessions. A few never mixed crystal meth with any other substance. A fifth of respondents avoided combining crystal meth with other uppers, such as cocaine, mephedrone, MDMA and ecstasy. This was in order to minimise the risk of adverse effects like hyperactivity, restlessness, overheating, paranoia and arrhythmia.

SAFE SLAMMING

Slightly less than half of the active slammers had strict rules about slamming. They avoided reusing or sharing needles, and said they always used alcohol swabs, tourniquets, distilled water and disinfectant cream to minimise the risk of infection and abscesses.

Four respondents treated the puncture wound with vitamin E ointment, which helps wounds to heal faster and better. A few slammers tested the potency and quality of the substance in advance by snorting or smoking a dose.

N. (53): "If there's any tina available, I first snort a small amount to see what effect it has, and to make sure it hasn't been cut."

TAKING A BREAK

Six respondents said they took short breaks during sex sessions. They withdrew temporarily from the sex setting or stepped outside briefly for some air in order to re-energise and give the body and mind some respite.

B. (47): "I took regular breaks during sex sessions. Then I'd go for a short walk outside, to get completely away from drugs, sex and men. I loved having a moment to myself. It always re-energised me and brought me more peace of mind."

FLUID INTAKE

Over half of the respondents took the sufficient consumption of fluids into account during and after chemsex. They avoided dehydrating beverages like alcohol, coffee, black tea, cola and other soft drinks but drank plenty of water, herbal tea or energy drinks.

FOOD INTAKE

Almost all respondents had their own tricks to compensate for nutritional deficiency during and after chemsex. One-third of the men regularly had a small bite to eat during sex sessions to improve their stamina and maintain their energy levels. A few ate fast food, but the majority preferred something soft like yogurt, fruit or a protein shake. Six respondents could only eat sweets during chemsex. Two men ate tuna or sardines immediately after slam sessions because of the supposed health benefits of (oily) fish.

SUPPLEMENTS

Many of the respondents took multivitamins and/or vitamin B-complex pills after a session of using in order to compensate for the consequent deficiency. Some said they took vitamin C to hasten their recovery from physical exhaustion and dehydration. Others dissolved some oral rehydration solution powder (ORS) in water. The drink compensates for the depletion of salts and sugars. A few took 5-HTP or tryptophan to help restore the dopamine and serotonin levels. One respondent took some olive leaf extract. According to him, it contains many antioxidants that quickly restore the immune system to a state of robustness after using.

ORAL HYGIENE

Some respondents allowed themselves plenty of time to clean their teeth thoroughly after chemsex. They used dental floss, a soft toothbrush and mouthwash to prevent tooth decay and give the mouth that fresh feeling.

L. (35): "I take proper care of my teeth before going to bed. Teeth grinding and not brushing takes a heavy toll on your teeth. I feel fresh again after flossing and brushing."

PHYSICAL ACTIVITY

Three-quarters of respondents made allowance for coming down and took a break for as much as one to several days in order to cope better with the effects of the phase. They watched movies, listened to music, played some sports or engaged in some light physical activity outdoors.

A. (44): "Even after days of non-stop use, I was still disciplined enough to do some sports, no matter how empty and exhausted I was feeling. And once re-energised, I could step back into regular life. You live in a timeless bubble when you're under the influence. And if you don't step out of it, you remain suspended in it, and before you know it you've used again."

SOCIAL NETWORKS

More than half of the respondents kept in touch with friends and/or acquaintances outside the user scene following a chemsex session. They planned diverting and relaxing social activities to help minimise craving and recover the full picture of their horizon. Respondents with crystal meth dependence had a hard time maintaining their social networks.

B. (60): "I regularly take a break of several weeks during which I do not use. I meet up with friends and visit museums, attend concerts or go to the cinema. That's when it becomes even more evident that there's more to life than chemsex."

SUMMARY

Using crystal meth has a significant impact on physical and mental health. Adverse effects are usually felt during the coming down phase. When sex under the influence is prolonged, these health-related problems become more severe and require longer periods of recovery. The amount of crystal meth taken, the combination of substances and the route of administration all play an important role in this regard.

Almost all the men with experience of slamming said that this route of administration exacerbated the adverse effects of coming down.

Some respondents bore the after-effects stoically. They had made a conscious decision to have chemsex under the influence of crystal meth (or other substances) and considered the side-effects a 'logical consequence' of taking crystal meth.

The most common adverse physical effects were disrupted sleeping patterns as a result of sleep deprivation, exhaustion due to an insufficient intake of food and/or fluids, and dental problems.

Frequently mentioned mental ailments suffered during the coming down phase were depression, mood swings and craving. Some respondents had suicidal thoughts.

The level of psychological well-being also depended on what the men did in the period after using and whether they got enough rest and food. The respondents who planned longer intervals between sex dates felt more psychologically stable than the group that used more often or continuously. Having a job or other (social) activities appears to be a protective factor.

To mute or mitigate the effects of coming down, regulate their level of use to the greatest extent possible and limit the potential health damage to themselves and/or their sexual partner(s), the men employed a variety of tricks and strategies.

Many men set limits on the components of usage in order to avoid the risk of spiralling downwards. These included the elements of the chemsex sessions (setting, duration, frequency of having chemsex) and the extent and procedure of using (combination use, dose size, following safe procedures). They also took measures to promote recovery and maintain a social network outside the user scene.

Respondents who used long-term experienced a range of psychological problems that affected their ability to function socially and in society.

Ten respondents said they used or had used excessively for short or prolonged periods of time. This overuse had progressed in incremental stages.

The men who slammed excessively started to use less and less safely. They also had trouble surviving in society and keeping up with regular activities such as working or studying.

9. INFORMATION NEEDS AND EXPERIENCES WITH CARE PROVIDERS



Knowledge of drugs, drug use, chemsex and all sorts of related issues such as HIV, hepatitis C, slamming, risk reduction and self-control is acquired and shared in different ways. Section 9.1 discusses the depth of knowledge and information needs of the respondents with respect to these matters.

During the interviews, ten of the respondents described themselves as drug-dependent and talked about their experiences with different healthcare providers and clinics. These experiences are outlined in Section 9.2.

9.1 INFORMATION NEEDS

At the time of the interviews, the respondents had been active in the chemsex scene for one to fifteen years. Most had been active for two to five years. Once someone arrives in the chemsex scene, they quickly come into contact with a wide variety of substances. More than half of the men had already been using a variety of substances for quite a while before they entered the chemsex scene. The substances used had been mostly confined to the more common drugs such as cocaine, ecstasy and GHB. A few had already had some experience with 4-MEC, 3-MMC and mephedrone. These substances are sometimes used to have 'better sex', but their use is usually not directly related to sex. A quarter of the men had only used alcohol, poppers or cannabis before their introduction to the chemsex scene. One respondent has never used anything at all before his first experience in the chemsex scene, not even alcohol.

J. (29): "I often see guys who have no idea that GHB can be addictive. It's a real shame that there's no practical information aimed specifically at gay men. This would prevent lots of high-risk behaviour and help to avoid lots of misery."

More than three-quarters of the respondents were asked about their need for information and support regarding chemsex, crystal meth and/or slamming. This topic was not discussed with the five who were interviewed online. User experience gained before entering the chemsex scene generally constitutes the basis of their knowledge of substance use. Men who'd only recently joined the chemsex scene possessed a limited amount of understanding. Knowledge of substances and drug-administration procedures is often acquired through experience or conveyed by sexual partners during chemsex. Majority of respondents also searched online for information about (new) substances, combination use and slamming. Men often had to turn to foreign websites for useful information about crystal meth and slamming. There's also a lot of discussion about drugs on sex-dating sites and apps, especially with regard to new substances such as 4-MEC, 3-MMC, NRG and MXE.

H. (54): "Before buying and trying new chems, I search online for nuanced background information on Dutch, English and German sites and forums alike. That's how I learn enough about the effects and potential risks. And then I decide if I want to try it."

The majority of respondents said they knew enough about crystal meth and combination use. They said they were fairly well informed about how it worked, its potential side effects and the risks associated with the more common drugs and drug combinations. Their understanding of new substances such as 4-MEC or 2-MMC was often very limited. There's not a lot of information available on the more reliable Dutch sites. Information about crystal meth is often found on US sites. These sites are generally didactic in tone and their focus is mainly on the dangers of using. The harm-reduction approach is usually hard to come by. This didactic tone and focus on deterrence frequently doesn't correspond with the respondents' experience or perceptions. The drug-specific information on these sites is in many cases limited to the basics about their effects and hazards. Topics that would be of real relevance to users and that relate to the context and reality of the way they use are usually not addressed.

Prime examples of this are the issues of passing out and drug-induced psychosis. According to most of the men, these mishaps are not the consequence of a lack of understanding of the substances but rather the result of a lack of boundaries within some sex networks, where people carry on for days on end while taking high doses of one or more types of drugs. More than half of the slammers said they didn't know the proper procedure for slamming, especially in the beginning. Many slammers do not possess sufficient knowledge to mitigate the possible risks of injecting in an unsafe manner. Furthermore, few are aware of what to do if something goes wrong while slamming. All slammers had their first slam administered by a sexual partner. Therefore, they usually had no idea if the correct procedure had been followed. They typically learned about the best techniques and harm reduction measures from others in the course of their 'career as a user'. The Internet is also an important source of information on safe slamming.

B. (37): "I think there's a great need for information about safe slamming. A lot of guys are not inclined to visit drug-treatment facilities for information. There's a great taboo around slamming. Many slammers don't even know how to administer a slam in the first place. I myself learned how to do it from another user, and it was only a year later that I was able to slam without help."

Most respondents feel that Dutch-language information about crystal meth, slamming and chemsex ought to be made available. They're currently dependent on foreign websites for such information. Meanwhile they're seeing a growing use of crystal meth in their environment. Considering this reality, a pragmatic response is required, they believe. After all, people are going to use anyway, so they might as well do so knowledgeably.

G. (53): "Clear and neutral information about crystal meth and slamming is essential. Ignoring the issue is

too easy, and even stupid. We need health-promotion information, and judgement-free information on substance use. That way users can weigh their pleasure needs against the risks when using. Which is why it's important to tailor the information according to user sub-group."

Four respondents, among whom were moderate and hardcore users, had serious doubts about the benefits of educational material regarding crystal meth and slamming. They believed balanced information about the substance and its procedure for administration would only arouse interest and curiosity in the drug, and in so doing lead people to experiment with crystal meth and/or slamming sooner than they otherwise might have. One respondent felt that information aimed at deterring crystal meth use would be a better approach, something he'd noticed in American campaigns. He believed portraits of users with rotten teeth would deter potential users.

H. (56): "I'd never have started using if I'd known what this drug could do to you. That's why Dutch-language information about crystal meth is essential. No one knows about the consequences before they use. Otherwise they'd never use in the first place."

Half of the men cited a particular need for specific information on substances (composition, duration of effect, combination use) and routes of administration (safe smoking and slamming). A minority wanted information about the related short- and long-term risks. Not only is there an insufficient understanding of the various substances, but also of their use during chemsex, their use in combination with other substances, and of slamming. Users are also inadequately informed about the risks of hepatitis C transmission. A lot of men said they didn't know all they should about sexually risky behaviour and hepatitis C transmission, and that information on the subject was hard to come by. Majority of the men cited this need, not least because of the prevailing stigma regarding hepatitis C within and outside the chemsex scene. Some of the men felt that the available Dutch-language information about hepatitis C was unclear, contradictory or not sufficiently comprehensive. The information that is available does too little to address gay users in the barebacking scene.

K. (46): "Hepatitis C is a hot topic in the barebacking scene at the moment. But there's far too little information available. And what is available is not sufficiently accessible. I read a piece on HCV in a German gay magazine last week, with practical information and clear instructions. 'Gosh,' I thought, 'so it's possible to present the information this way too!' But I've never seen anything like it in this country [The Netherlands], and it's about time we had something like this."

G. (53): "Hepatitis C is a thorny subject within the scene. A lot of guys don't know the main risks of transmission. A non-stigmatising campaign is needed."

There are several levels of crystal meth use: curious, novice, experienced, and dependent user. The information needs to vary according to level. Opinions differ regarding which of the levels any information ought to be tailored towards. Some men think it's of particular importance to tailor information for the education of novice users, while others think it's the experienced or dependent users in particular that need instructive information.

There were also lots of different ideas regarding the means through which information should be made available: digitally via websites or apps, in printed form, or by oral dissemination. Some of the men declared a preference for an informative website with a built-in user forum. Users could share tips and tricks about safe use and self-control via the forum, and in so doing learn from each other. Two respondents pointed out that if information were to be provided on an individual basis, face-to-face or via email, for instance, the timing of this knowledge transfer would be worth some consideration. In their opinion, the second half of the workweek was the best window. The information would thus be transmitted and received before the weekend began, which is when chemsex sessions mostly take place. Furthermore, the most debilitating effects of coming down from the weekend before will have worn off by then. Everyone agreed that not only was the content important, but so was the tone: it had to be nuanced, factual, neutral, accessible and non-stigmatising. A lot of men have a need for information that lays out the facts, offers tips and explains the various options so they can make informed decisions at their own discretion.

C. (43): "I think there's a great need for a Dutch website on crystal meth. A nuanced and practical website with comprehensive information and a user forum gets my vote. It'll need to be accessible, have a neutral tone of voice, and be comprehensible to both novices and hardcore users. At the moment, I'm forced to rely on American websites for information on crystal meth."

A neutral, non-stigmatising approach to drug use, chemsex and sex without condoms is notably absent. Five respondents felt they'd been judged negatively by people in the healthcare sector because they'd had sex without a condom and felt stigmatised because of this. A pragmatic attitude towards drug use and barebacking is necessary, an attitude that is judgment-free and in line with reality. According to users, awareness-raising campaigns need to focus more on risk-reduction strategies.

T. (44): "It's a challenge for people in the healthcare sector to take barebacking as given, and to refrain from stigmatising it. The practice is not only current, but also growing rapidly in popularity. Those who bareback are automatically pigeonholed as mentally disturbed. In this respect, German healthcare is far ahead of the Netherlands. In Germany, information is provided specifically for men who prefer to bareback. If you want to reach this group of men, calling their sexual choices into

question is the dumbest thing you could do. You're hoping to make contact with the men in this group but you're turning them right off before you've even got started."

B. (32): "Many professionals still keep going on about condom use. But take it from me, there's a group within the gay scene that does not give a damn. Sex without condoms is ultimately much more natural and pleasurable. Men prefer to fuck without and need alternative risk-reduction strategies. Accepting and therefore anticipating this trend is the major challenge for support services."

9.2 EXPERIENCES WITH CARE PROVIDERS

Ten respondents no longer had their consumption of crystal meth under control, or had previously experienced loss of control. These men also used (or had also used) crystal meth on occasions that had nothing to do with chemsex, and they considered themselves dependent on the drug. Two of these men were also dependent on GBL and mephedrone. Six of the ten were HIV-positive; eight slammed.

Three of these ten men had never discussed their crystal meth use with a professional. They were trying to break the habit on their own. One of them had started using again after months of managing not to use, but he was using less excessively than before by the time he was interviewed. It was impossible to tell whether the other two would succeed in quitting. They were in the middle of their attempt to quit when the interviews took place. There has been no contact with these two since the interviews.

The seven other respondents with a dependency had sought professional help at least once. This happened via a GP or other care provider with whom they were already in contact. Contact with healthcare providers outside of drug-treatment services, such as with general practitioners for instance, was often unsatisfactory. The men often felt they weren't being taken seriously or that they were treated unpleasantly, and they encountered a lack of understanding regarding their particular issues. Hoping to get help regarding his consumption of crystal meth, one respondent talked to a medic with whom he had regular contact. The medic didn't know anything about crystal meth and his/her reaction made the respondent feel distinctly uncomfortable. Another respondent has been admitted to drug-treatment clinics three times on account of using crystal meth. He talked to his HIV counsellor about his dependency problem, but she didn't know where to refer him for help. She was able to listen without passing judgment, though.

All of the men said their GP had little to no understanding of chemsex, crystal meth and slamming. At best, the discussions about taking crystal meth would end in them being referred to the general drug-treatment centre. Some respondents had encountered so much incomprehension that they hadn't bothered going through with their request for support and had left disillusioned.

S. (40): “When I told my doctor that I slammed crystal meth, it was clear that she knew nothing about the drug. She launched into the standard story about ecstasy and GHB, and said she could only refer me if I used one of these substances on account of my health insurance coverage. I was stunned. I told her just how hooked I was, but she responded in an impatient and irritated manner, and completely failed to discern the seriousness of my situation. I did eventually get a referral, but from her I got absolutely nothing.”

Talking to a doctor about their excessive use of crystal meth was the first time two of the men had talked about their problem to anyone outside the user scene. Seeking help is often a big step. Users typically hope that taking this step will initiate change. It’s hugely disappointing when this attempt to get help fails. It increases the despair they are already feeling about their situation, which is often a trigger to use again.

B. (47): “My doctor referred me to a drug-treatment clinic in 2012. But I realised after two sessions with them that I was not in good hands. It was only after I managed to kick the habit on my own that I understood that both my doctor and the professionals at the clinic had been of no use to me whatsoever. They basically abandoned me to my fate.”

Five men had had experience with drug-treatment services. One respondent decided to try to kick the habit without help following a cancellation of his appointment by the clinic, but was soon using excessively again. The other four had undergone the intake process at a drug-treatment facility and noted that the healthcare workers had little or no understanding of chemsex, crystal meth and slamming. Two respondents quit the treatment because of this. They have no trust in the aforementioned clinic and have postponed any further action.

S. (40): “I initially sought help at a drug-treatment facility in Amsterdam. I made an appointment by phone. It became clear during the intake interview that she knew absolutely nothing about crystal meth. That particular clinic has acquired a bad reputation among the gay men who’ve used it. I know several guys who decided they’d had enough of the clinic’s working methods and disrespectful manner.”

L. (35): “I registered at the local drug-treatment clinic. During my intake interview I found myself having to give an introductory course on crystal meth. She knew nothing about crystal meth. She didn’t know you could inject the drug nor did she know its street name. She even asked if tina was my ex-girlfriend’s name. I’d had just about enough by then. It had been a complete letdown. I went straight back to using.”

The other two men submitted to treatment at the clinic, despite their doubts about the facility staff’s expertise.

They took part in group therapy on an outpatient basis in a day programme that focused primarily on drug use. Most of the other participants in the group were dependent on cannabis or alcohol. As many of their co-participants had nothing to do with the conjunction of drugs and sex, the men did not feel at ease during the group discussions. They often felt ashamed and found it difficult to be candid about their use of drugs during sex. They had a strong suspicion that even the professionals would be repelled by their experiences, which further diminished their motivation to be open and honest during one-on-one sessions. Both men dropped out of the programme early. One of the men managed to bring his level of use under control without further help from anyone else. He now uses only occasionally. The other man made two further attempts to quit with professional help: at a rehab clinic abroad and again at a drug-treatment facility in the Netherlands. He eventually managed to kick the habit on his own. He hadn’t touched crystal meth or GBL for six weeks at the time of the interviews, although he had begun to drink excessively.

User experiences with the drug-treatment facilities are far from encouraging. The respondents felt misunderstood and ashamed, and didn’t feel anyone had listened to what they had to say. All in all a disappointing and frustrating experience.

F. (30): “The weekly conversation with the addiction therapist was beyond belief. I finally worked up the courage to give him a little hint about what was going on but saw that he was horrified by my story. He was disgusted by my lifestyle. So I started clamming up, and felt less and less inclined to share my story with anyone. When I think about it now, I realise I simply couldn’t be myself under those circumstances. His condemnation of my lifestyle filled me with shame, which then made me reserved. There’s a huge taboo around slamming, crystal meth and barebacking within the healthcare and drug-treatment sector. I felt a lot better when I spoke to experienced peers who work at the clinic. That makes everything so much easier.”

M. (42): “I finally started my treatment at the local drug-treatment facility in early 2014. But I broke off contact after six sessions. I was appalled by their support and guidance. They knew little about using crystal meth, let alone in connection with sex. They were not up on the latest news regarding which chems were currently being used and had no idea about what was happening in the gay scene.”

Three of these five respondents with drug-treatment services experience turned to private rehab clinics after their disappointing experience with drug-treatment facilities. Two of them turned to the same private clinic in the Netherlands, and recalled that it was immediately evident during their intake interviews that the staff here had some expertise regarding chemsex. The staff had an open-minded attitude towards crystal meth and were ready to delve into the subject. This approach is missed at general drug-treatment facilities. Not all of the

professionals at the private clinic were complete experts in all the necessary areas, but here, for the first time, the men felt listened to and understood. This gave them hope and allowed them to believe in the possibility of a drug-free life, which raised their level of motivation.

S. (40): "After the let-down at the local drug-treatment facility, a friend of mine got in touch with a private clinic on my behalf, without my knowledge. I had my intake interview a week later, and it was such a relief. They were familiar with crystal meth, but they also said they'd had few such requests for help. I already felt good about the intake, a nice conversation that left me with a warm feeling. I'd finally been understood. Very professional!"

The other two each choose a different course of treatment. One went to a detox ward and was then transferred to an inpatient treatment ward where he completed the three-month treatment. The other opted for an outpatient course of treatment. This consists of a year-long session of weekly coaching and group therapy, which included a group for men with sex addiction. Both men were satisfied with the approach offered by the private clinics. However, they found some aspects of the programme difficult and they missed the opportunity to share their stories with others who'd had similar experiences. The feeling of being heard along with the level of expertise displayed by the staff in relation to taking crystal meth during sex gave them the confidence to continue treatment. The man who was transferred to the inpatient treatment ward began using excessively again after steering clear of crystal meth for a short while after treatment. Four months into his outpatient treatment, the other man is still drug-free.

S. (40): "I'm so glad that my counsellor is open to my view of my history of using and that the conversation focuses on what I find important. We discuss all the options for treatment and a personal treatment plan is drawn up according to my suggestions. Nothing is decided without my consent. I saw a psychologist for six months for the chosen course of treatment. Our meetings go beyond the nice conversations I have with my coach. The group discussions do me good, too, though I miss hearing other slammers talk about their experiences. You can support each other better when you share similar experiences."

L. (35): "The set-up and guidance provided at the private clinic were terrific. I was taken seriously so I became increasingly open about my murky history of sex and drug-use. Everyone had a harrowing story of their own, but none of us ever got judged. The group discussions felt good, though I often found them distressing. People almost fell off their seats in shock when during one of the early group discussions I related the story of how I had allowed myself to be fisted while under the influence of crystal meth and suspended in a sling. But I eventually revealed everything about my past activities: online dating, the sex networks, using and slamming, the orgies, everything. Letting it all out was a huge relief."

All ten respondents with dependency problems find the current services provided by the drug-treatment services unsatisfactory in relation to men who have chemsex and/or use crystal meth. They note a lack of knowledge, weak manner of support, and lack of an effective treatment, and they've heard the same complaints from other men. Most of them miss easily accessible initiatives such as needle exchange programmes or informative drop-in evenings for men on the subject of chemsex and/or crystal meth use. Half of the men would welcome discussion groups or drop-in evenings for former users as a way to support one another.

M. (42): "I find it hard to believe that in gay-friendly Amsterdam there isn't a single organisation offering easily accessible services to gay users. Why is there no daytime drop-in centre, for instance? Or a needle exchange programme for gay men?"

S. (40): "There's a lack of targeted therapies and discussion groups for gay drug users. There's also a lack of preventive care for men from the chemsex scene. Why isn't information provided at pubs, for instance, or saunas? It is astonishing that many professionals in the drug-treatment and healthcare sector have absolutely no idea of the seriousness of the consequences of using crystal meth. They have no idea what's happening in the scene. GPs and doctors specialising in drug-treatment still don't know what tina is, meanwhile the chemsex scene is growing."

F. (30): "Why aren't there any easily accessible harm-reduction programmes in the Netherlands, such as they have in London? There they visit users at home to hand out free syringes and needle disposal containers, an added advantage of which is that it allows them to maintain regular contact with users, so they know what's going on in the scene. I'm also aware of no discussion groups in Amsterdam for gay men who have chemsex. Self-help groups can be very beneficial - they provide a space for you to share experiences without being judged or rejected, and this gives you strength. You can bolster each other's will by showing each other that it's possible to have great sex without crystal meth or GBL. My self-confidence in this area is sadly lacking."

SUMMARY

Users' factual knowledge of drugs tends to be quite limited at the start of their 'career in using'. Knowledge of drugs and related issues is acquired through the experience of using or shared between sexual partners. Majority of the respondents also searched the web for useful information. Respondents were fairly well informed about the more common drugs, but the level of knowledge of new psychoactive substances (NPS) varied.

A detailed understanding of all aspects of slamming is often lacking. Information about crystal meth and slamming is largely sought on American websites, which are often didactic in tone and emphasise the dangers of using. Not only does this put them off, but it also fails to reflect the respondents' reality. Furthermore, the sites don't cover relevant topics. Most respondents feel that Dutch-language information about crystal meth, slamming and chemsex ought to be made available.

Users are often inadequately informed about sexually risky behaviour and the risks of hepatitis C transmission. Most of the men needed this information, not least because of the prevailing stigma regarding hepatitis C within and outside the chemsex scene. Men that bareback need information about hepatitis C tailored specifically to them.

Opinions differ as to which type of user should be targeted and in which form the information about crystal meth, slamming and chemsex should appear. Majority of respondents felt that this information would need to be nuanced, factual, neutral, accessible and non-stigmatising. Just over a quarter of respondents pleaded for acceptance of condom-less sex within the health services. They need information on alternative risk reduction strategies.

Ten respondents said they were crystal-meth-dependent. Seven of these had sought professional help via a GP or care provider with whom they were already in contact. These encounters often proved disappointing. A lot of men felt they weren't being taken seriously or that they were treated unpleasantly. They also noted a lack of understanding of chemsex and crystal meth among the professionals.

Four respondents had had some experience with drug-treatment services. They found the staff had little or no understanding or experience of chemsex-, crystal meth- and slamming-related issues. When they participated in group discussions they missed the opportunity to connect with others who'd had similar experiences, and often felt ashamed and reluctant to participate with candour.

Two respondents had turned to private rehab clinics in the Netherlands. The staff at these clinics displayed some degree of expertise regarding chemsex. The two also took part in group therapy organised specifically for men with sex addiction. The feeling of being 'heard' along with the level of expertise displayed by the staff in relation to taking crystal meth during sex gave them the confidence to continue treatment.

The respondents with dependency problems find the current services provided by drug-treatment services unsatisfactory in relation to men who have chemsex and/or use crystal meth. Most of them miss easily accessible initiatives such as needle exchange programmes or informative drop-in evenings. Half of the men would welcome self-help groups as a way to support one another in their effort to kick the habit.

10. SUMMARY: OBSTACLES WITHIN THE HEALTHCARE SECTOR



Via interviews with professionals from the emergency services and the general, sexual and mental healthcare services, we have identified the extent to which the issue of crystal meth use in conjunction with sex is noticed, and the degree to which this has led to specific demands for support and any corresponding tailored provision of support.

Problems relating to crystal meth use and chemsex are noticed most often by the professionals who provide other forms of care to MSM, such as HIV counsellors and specialists in the field of MSM and sexuality. After all, they're already in contact with this group for the purpose of HIV treatment, STI checks or other MSM-related health services. The subject of crystal meth use comes up fairly regularly in the men's discussions with these professionals, but it is rarely the original reason for the contact. Healthcare professionals typically referred clients with problems relating to chemsex or crystal meth use to the local drug-treatment facility. They were largely (or completely) unaware of what happens following the referral, and had no idea if the facility to which they'd referred their client had offered appropriate treatment. Many of professionals were doubtful that they would have, and there's rarely any collaboration between institutions, or feedback or follow-up on what becomes of clients.

Support services that are not aimed specifically at MSM, such as the emergency services, only encounter this problem to a limited degree. The emergency services focus largely on the monitoring of vital signs. The question of

which specific drug a patient has taken is rarely addressed here, and sexual orientation and drug use in conjunction with sex not at all.

The drug-treatment service does not have a clear idea of the extent to which men from this group request help for crystal-meth-related problems. At the moment, it looks very much as if the increase in crystal meth use noted by users themselves has yet to result in a tidal wave of registrations at drug-treatment facilities.

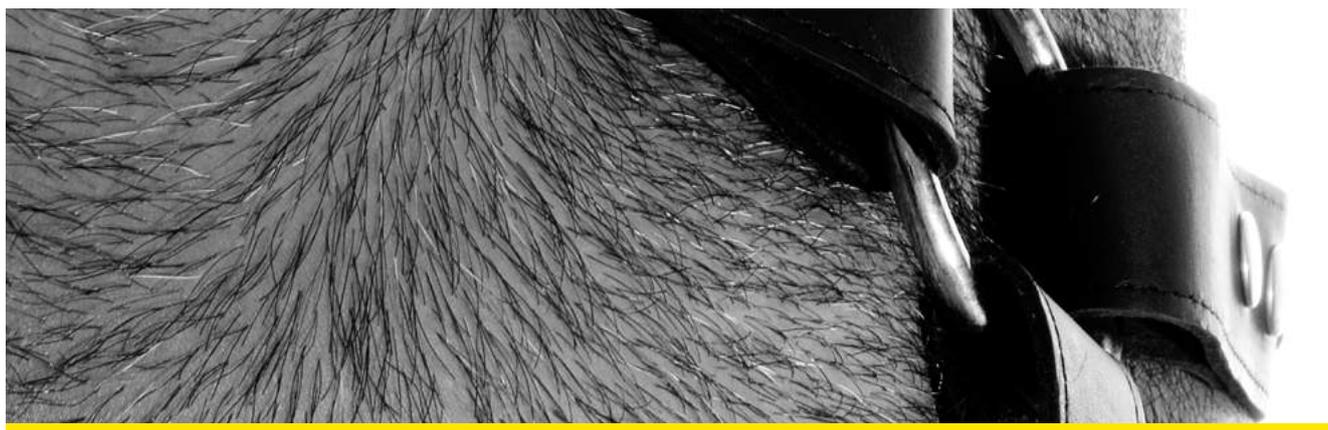
As crystal meth use isn't specifically noted when clients register at drug-treatment facilities, the potential trends in problematic use of the drug aren't detected. Only two institutions have recently begun to note crystal-meth-related requests for support. Since 2010, methamphetamine-related data has been entered in a separate category in the National Alcohol and Drugs Information System (LADIS), where treatment data is registered. But although it occupies its own category in LADIS, it's not clear why the other drug-treatment institutions we interviewed do not record this information. As a result, there is no data on national trends.

Sexual orientation and the setting of usage is only included in clients' personal files. Which is why trends in the support needs of specific groups are barely noticed. Consequently, the provision of support tailored to meet these specific needs remains undeveloped. Treatment within the drug-treatment sector is usually (mainly) geared towards abstinence. Both users and professionals from

outside the drug-treatment services are in agreement that the support currently on offer does not correspond with the current needs.

At present, not a single programme of treatment offered by the Dutch drug-treatment services focuses specifically on chemsex and/or crystal meth use by MSM.

11. CONCLUSIONS AND RECOMMENDATIONS



11.1 MONITORING

This report was prompted by signals from the MSM community and professionals in the field in connection with the rising use of crystal meth and the intravenous administration ('slamming') of drugs among specific groups of MSM in the Netherlands. Using crystal meth and slamming drugs is almost always done in a sexual setting (chemsex). Frequent users of crystal meth run a great risk of becoming dependent on it, especially if they inject it. The long-term effects of using crystal meth and slamming drugs can potentially cause serious damage to physical, mental and sexual health. Up-to-date national figures to corroborate the increase in crystal meth use and slamming are lacking. At present, Mainline and Soa AIDS Netherlands believe the number of MSM using crystal meth or slamming drugs is still relatively small. However, it is likely that this group will continue to grow in the years ahead. In recent years, crystal meth has dropped in price from about 200 euros per gram to between 100 and 150 euros per gram. It is expected that as the price of crystal meth continues to fall, the drug will become affordable for, and therefore accessible to, a larger group of MSM.

An increase in crystal meth use and the slamming of drugs has already been registered in other European countries like France, Germany, Spain and the United Kingdom. Some drug-treatment clinics in London noted a shift from smoking to slamming within the MSM community between 2011 and 2013. During that period, they noted within their client base a quadrupling of crystal meth users who were injecting. Four of the respondents in this report

had already had their first experience with crystal meth abroad by 2005. The other men we interviewed all started using after 2010. It therefore appears that crystal meth and slamming began to gain popularity in the Netherlands from that year onwards. As far as we can tell, the consumption of crystal meth and the slamming of drugs are taking place mainly in the Randstad (area around the 4 mayor cities) and in the southeast and east of the country.

From past experience we know that drug use by MSM tends to set the trend for drug use in the general population. For instance, it was in the gay scene that ecstasy and GHB first gained popularity. The same could happen with crystal meth and slamming. Dealers say that most of their current customers are MSM, but that they've also sold to heterosexuals. Data collected by Europe's drug monitoring agency EMCDDA shows that in recent years, a number of methamphetamine laboratories have been raided in Belgium and the Netherlands. This may indicate a growing demand for the drug.

This status report outlines the context of crystal meth use and the slamming of drugs on the basis of interviews with 27 men. However, more data is needed. Not only is it of great importance to know how many and which drugs MSM are using, but also to know what their information and support needs are in order to draw up a comprehensive, useful and effective policy on prevention and healthcare.

Recommendation: *A new national behavioural study of a broad group of sexually active MSM is required. This study would provide a better understanding of the situation regarding chemsex as well as the information and support needs of MSM that have chemsex.*

Several national and international studies have demonstrated a relationship between drug use and sexually risky behaviour. More than 25 American, British and Australian studies have demonstrated this relationship with specific regard to crystal meth (see Chapter 3). The RIVM (national institute for public health and environment) has decided that from 2016 it will include a question about drug use in SOAP, a database containing a variety of data collected from Dutch STI clinics (see Chapter 4). Soa AIDS Netherlands and Mainline applaud this decision. However, the question remains optional, i.e. it is not mandatory to ask this question of MSM; municipal health organisations for preventive healthcare are free to decide whether or not to fill in the field in question.

Recommendation: *We recommend that all municipal health organisations for preventive healthcare always fill out the currently optional SOAP question about drug use during every MSM visit to an STI clinic. This would allow for a better understanding of the (regional) trends in drug use among MSM and establish the relationship between the use of specific drugs and STI transmission.*

Intravenous drug use was recorded in SOAP until 2014, but the question was subsequently dropped. The question about users' preferred route of administration was not included in the optional question about drug use that was reinstated in SOAP in 2016. The reason for this omission was that earlier analysis had revealed few new cases of HIV among intravenous drug users who visited STI clinics (see Chapter 4). The wisdom of the decision to omit information about the route of administration in the SOAP registry is questionable. Different routes of administration come with different risks of transmitting infections. Earlier in this report we mentioned that two drug-treatment clinics in London had noticed a shift from smoking to slamming among MSM that took crystal meth. Experience has shown that trends in drug use tend to start in London before spilling over into the Netherlands. It would be similarly wise to keep a record in SOAP of users who engage in the rectal insertion of drugs ('booty-bumping'). This route of administration is very harmful to the intestinal mucosa, rendering users vulnerable to HIV and STIs (see Chapter 3).

Recommendation: *In view of the fact that slamming might also be gaining ground in the Netherlands, the RIVM should include an enquiry about intravenous administration and the rectal insertion of drugs in the optional SOAP question about drug use.*

Chemsex mainly takes place in private settings. Some drugs, particularly the new psychoactive substances (NPS), are usually bought online. This same also applies to slamming paraphernalia (syringes, needles, etc.). New developments are therefore much less visible in the public sphere, whereas changes in drug use can happen very quickly. This demands better monitoring of trends in drug use and routes of administration.

Recommendation: *Better monitoring of drug trends is vital. We specifically suggest funding a national monitoring mechanism that by triangulating the different (local) sources and monitoring what's happening online can create an early-detection system for spotting new trends in drug use.*

It is quite possible that crystal meth is here (in the Dutch drug scene) to stay. It is therefore essential that we keep a record of its use in the national drugs monitor. The national drugs monitor does not currently keep a systematic record of crystal meth use. The Trimbos-institute's Monitor for Drug-related Incidents (MDI) does however keep a record of drug incidents appointed paramedics or doctors in Accident and Emergency (A&E). However, this monitor does not have a separate category for recording crystal meth use. The general drug-treatment centres are required to enter their client registration information into LADIS, the Dutch Alcohol and Drug Information System. But for reasons that remain unclear, crystal meth use isn't always recorded in the methamphetamine (crystal meth) category but in the 'amphetamines or other substances' category. A number of private clinics keep a voluntary record of crystal meth use. It would be prudent for more private clinics to do the same.

Recommendation: *We recommend that all drug-treatment institutions that enter information into LADIS, as well as the emergency services (ambulance services and emergency rooms) affiliated to the Trimbos Institute's national Monitor Drug Incidents (MDI), record crystal meth use in a separate category.*

The review of publications described in Chapter 3 revealed that using crystal meth could affect HIV-positive MSM's adherence to treatment. However, the studies described in the publications were not exactly recent. Furthermore, they were carried out in the United States, where access to treatment is worse than it is in the Netherlands. Finally, these studies were based on an adherence level of over 90 per cent, whereas nowadays taking at least 85 per cent of your doses is an acceptable level of adherence. The question is to what extent is low adherence to treatment a problem among Dutch MSM that use crystal meth. What percentage of frequent users has a detectable viral load? How often does virological failure occur? How often does the development of resistance occur? We need data obtained in the Netherlands if we're to answer these questions.

Recommendation: We recommend that all HIV clinicians and HIV counsellors with patients who display poor adherence to treatment enquire in a judgement-free manner about their clients' drug use and ask explicit questions about which specific drugs they are taking and in what way they administer them. It is further recommended that the HIV Monitoring Foundation (SHM) keep a record of all virological failure resulting from drug use and note all cases of the development of resistance to treatment.

11.2 PREVENTION

Most of the men interviewed for this report said they never used condoms when having sex. They'd usually already made the decision to have condom-free sex before taking drugs and made it clear that awareness campaigns that lecture them about using condoms simply don't reflect their reality. Some of the men who don't use condoms employ other risk-reduction strategies, the most common of which is viral-load sorting. HIV-positive men with an undetectable viral load are considered the safest men with whom to have unprotected sex and appear to be the most sought-after sexual partners. The mutual exchange of information regarding HIV status and viral load appears to work in smaller groups. This diminishes as groups expand in size and become more anonymous. Discussing these matters becomes a less obvious thing to do in these bigger and more anonymous groups. Furthermore, during these larger sex parties, new participants are sometimes found online and invited to join the party. When this happens, additional risk is introduced because any previous overview of everyone's HIV status and viral load is soon lost.

Recommendation: To provide better preventative measures that reflect the reality of MSM that have chemsex and who choose to do so without condoms and yet would like to minimise the risk of contracting HIV, it is vital that we provide instructive information about the benefits and drawbacks of the different risk-reduction strategies. This information should highlight, among other things, that the mutual exchange of information about everyone's HIV status, HIV and STI testing habits and viral load is vital if the participants wish to implement the risk-reduction strategies successfully.

Using crystal meth makes MSM particularly vulnerable to contracting HIV or other infections such as hepatitis B and C through a variety of ways. Eleven of the respondents had or had had hepatitis C. All eleven were HIV-positive. Three of them had contracted hepatitis C again after they'd already been successfully treated for it. Most of the men did not know precisely which sexual acts and conditions entailed the risk of contracting hepatitis C. They thought it mainly had to do with having sex without condoms. On account of this belief, they overlooked the fact that blood-to-blood contact in particular is a

major route of infection. The hepatitis C virus may be transferred when fisting is practiced without latex gloves, for example, or when body parts, the area where sex takes place or the sex equipment isn't disinfected before switching partners. Neither were most of the men aware of the possibility of infection by different genotypes of hepatitis C (see Chapter 6). Respondents demonstrated a need for instructive Dutch-language information about hepatitis C and about minimising the risks of transmission (see Chapter 9). This information is already available through mantotman.nl, among other sources, but does not appear to be reaching this group. This means an alternative method or channel must be found in order to reach this group with this information.

Recommendation: A much greater effort needs to be made to get instructive information about hepatitis C into the hands of men who use crystal meth and/or slam, and who therefore are at greater risk of contracting hepatitis C. HIV-negative men who engage in group sex under the influence of crystal meth or who slam drugs should be given a realistic picture of the risks they run with respect to hepatitis C, particularly in relation to intravenous drug use.

Smoking and slamming are the most popular methods of administering crystal meth. More than two-thirds of the respondents had had experience with slamming, even though this was not an inclusion criterion for participation in the study. Only 8 respondents said they'd never slammed and had no interest in ever doing so. It could be that the normalisation of injecting steroids has contributed to the erosion of the taboo surrounding needles. EMIS 2010 revealed that 9 per cent of Dutch MSM had had an experience of injecting steroids or drugs (EMIS did not split the two categories any further), thereby placing Dutch MSM among the top needle users in Europe.

Respondents said their first few slams were typically administered by someone else. Thereafter, people picked up slamming technique from one another, and in so doing often passed on incomplete and inaccurate instructions. A lot of information about technique and procedure was also gleaned from the internet. All in all, the respondents displayed an inadequate level of understanding of safe injecting. A significant proportion of respondents who slammed had suffered bruising and/or abscesses around the point of insertion for slamming. This indicates incorrect slamming technique. There is also little understanding of how to safely dispose of needles using needle disposal containers so as to prevent the occurrence of needle-stick injuries. Most of the men were also unaware of the existing needle exchange facilities in the Netherlands.

The review of international publications (Chapter 3) revealed that if there are no sterile syringes and needles at hand while there are still drugs available for consumption, syringes and needles tend to be reused and/or shared. The question is to what extent this also sometimes happens

among the men interviewed for this report. The majority generally claimed not to share syringes and needles, but the interviews did not press for further details regarding what happens when they run out of needles and syringes while there are still drugs at hand.

Several respondents said they bought and/or used their crystal meth abroad. There are indications that the crystal meth available in the Netherlands may be less potent than that which is available in Germany or the United States. This can result in undesired effects and overdosing. This is especially so when a dose of crystal meth with a higher than expected level of potency is slammed. This bit of information needs to be reintroduced in educational material, by recommending, among other things, that it is advisable for users that slam to have the potency of their crystal meth checked prior to slamming. They can do so by submitting a sample to a testing facility, or by first smoking a dose so as to gauge its potency themselves.

Recommendation: *Highly instructive and accessible Dutch-language information on slamming is of vital necessity in minimising unnecessary harm. We need to examine the means by which raising awareness of, and accessibility to, needle exchange facilities can be achieved among this group. In so doing we will be promoting the use of needle disposal containers to prevent the occurrence of needle-stick injuries.*

Respondents cited various techniques for enhancing the effect of smoking, smoking more efficiently, and sometimes also for minimising the potential health risks. It's not entirely clear if these techniques are actually effective or if they are in fact damaging to health. In order to gather and disseminate instructive information that connects with this audience, an investigation must be carried out to identify which of the currently believed smoking techniques are actually effective and which aren't. The same applies to the sharing of glass crystal meth pipes. The intense heat absorbed by these pipes when held over a flame can result in dry and cracked lips. In theory this could pose a risk of HIV and hepatitis B and C transmission if one user inadvertently leaves blood on the pipe stem and the person with whom the pipe is being shared also suffers from dry or cracked lips.

Recommendation: *In order to gather and disseminate instructive information on smoking crystal meth, an investigation must be carried out to distinguish the less harmful techniques from the harmful ones, and the risks posed by sharing pipes must be clarified.*

Using crystal meth and taking drugs by intravenous means often entail considerable physical and psychological problems, especially during the coming down phase. These include insomnia, the insufficient intake of food and/or fluids, overdosing, psychosis, depression and suicidal thoughts. Some of the men in this report

implement harm-reduction strategies to minimise the chance of these problems occurring, but the effectiveness of these strategies is not entirely clear. Strengthening the harm-reduction strategies among the target audience may assist them in self-regulating their use of crystal meth in a way that minimises unnecessary problems. For example, focusing on the prevention and detection of the symptoms of psychosis or suicidal tendencies that can result from using crystal meth may help users to keep these potential problems under control. And by informing MSM about which organisations they can turn to in the event of acute problems, we could lower the threshold to seeking help.

Recommendation: *There is a vital need for highly instructive Dutch-language harm-reduction information on crystal meth and chemsex that connects with the target audience. This material should provide information about the prevention of potential problems and about what to do in the event of a drug-related incident, among other things.*

11.3 HEALTHCARE

From the interviews with professionals in the drug-treatment services it emerged that few are at all familiar with crystal meth and chemsex. The MSM interviewees confirmed this. They encountered a lack of understanding regarding chemsex and crystal meth among the professionals from this sector, but also among general practitioners. As a result, they lost confidence in the healthcare sector's ability to provide the appropriate treatment and in the healthcare professionals' likelihood of even understanding what they were talking about at their very first encounter when they sought help. In addition, the men often encountered a lack of empathy and sensitivity among professionals when they sought help, which didn't make them feel safe enough to divulge their problems with candour. The sexual context of using constitutes the greatest barrier to comfort and candour in seeking help.

Professionals in the STI and HIV field are generally a bit better informed about chemsex. Some of the STI and HIV professionals interviewed for this report had clients who use crystal meth. Nonetheless, they still weren't sure how to provide effective help or where to refer the clients who were experiencing drug-related problems. Some of them said they refrained from referring MSM to drug-treatment services because the impression they had of these institutions was that they specialised in helping people who use alcohol, heroin and crack cocaine.

Recommendation: *The basic understanding among professionals with regard to crystal meth and chemsex must be enriched without delay to improve the first contact of MSM with GPs and the people who conduct intakes at drug-treatment facilities.*

It must be stressed that chemsex does not lead to problems in most cases. Furthermore, not every MSM with problems relating to chemsex should be automatically referred to a drug-treatment service. Many men prefer to practice the maintenance of control and self-regulation themselves, and are only seeking ways to minimise the (sexual) risks of drug use (risk reduction). As MSM appear to have reasonably good access to STI and HIV care, an easily accessible form of care provision ('co-located care') could fit the needs of MSM. This could include a dedicated walk-in drug-consultation offering at STI clinics, or some other easily accessible walk-in service dedicated to MSM. At the places offering co-located care, MSM would be able to take STI tests, participate in group discussions about chemsex, have their drugs tested, exchange used syringes and needles for new ones, and obtain information about minimising drug-related risks (including sexual risks). And those who need more specific support relating to their drug use can be referred to the most appropriate drug-treatment facility.

Recommendation: *Consideration should be given without delay to the development of an accessible form of care provision in the area of drug use and sexual health for MSM in order to make effective referral (to addiction clinics, for instance) possible. This could be created through accessible, integrated facilities (co-located care), such as a joint venture between STI clinics and drug prevention and/or drug support services.*

The primary reason for MSM to use drugs during sex is the enhancement of sexual experience. Crystal meth is one of the most effective drugs for achieving this end. According to the MSM interviewed for this report, using crystal meth and slamming gives them an experience of complete freedom and allows them to feel sexually powerful and attractive. Some of the men consider any adverse effects the unavoidable price of using, and feel these effects are outweighed by the experience of sexual ecstasy, the sense of belonging and the shedding of everyday concerns. Others find the adverse effects debilitating. They exhibit symptoms of depression, and some experience suicidal thoughts. This soon creates the need to take another dose of crystal meth. Some men find themselves in a vicious circle of self-medication (take a dose - experience symptoms of depression - develop a craving - take another dose). Almost all of the men claimed the craving generated by crystal meth is much stronger than it is with other drugs. They tended to take another dose of crystal meth much sooner than planned after the previous dose and participated in sex sessions for much longer than planned. The craving is even stronger when the drug is injected (slamming). Some of the men said they were barely or not at all aware beforehand of this consequence of slamming. Eventually, the frequent use of crystal meth during sex causes some men to lose the ability to have sex without the drug. The main reason for using the drug - enhancing sexual experience to the maximum degree possible - gives way to a completely different reason: crystal meth

becomes necessary to have any sex at all. It may also be the case that the sexual component eventually fades with long-term use of crystal-meth. Using occupies centre stage, and these men often become socially isolated.

The exact size of the MSM group currently experiencing problems with crystal meth and chemsex is not entirely clear. This makes it difficult to estimate the size of an appropriate response in the Netherlands. What is clear is that institutions for mental health and drug-treatment services are insufficiently aware of the context of chemsex and the associated problems. This makes appropriate and effective referral difficult. It is therefore of great importance to develop specific training for healthcare providers to help them create services that reflect and fit with MSM lifestyle. That means understanding that they should not immediately consider chemsex a problem, among other things. This would help ensure that MSM perceive the service as accessible. Furthermore, a range of training programmes could contribute to the expansion of knowledge in the field with respect to this issue, and to a shared vision of the 'framing' of chemsex. The right frame could unite two worlds: the world of MSM that choose chemsex to enrich their sex lives, and the world of healthcare professionals currently inclined to perceive drug use from a medical perspective, and who, as a result, see almost nothing but its problematic aspects.

Recommendation: *In addition to the need for caregivers in institutions for mental health and drug-treatment to be well informed about the drugs MSM use during chemsex, they also need to be knowledgeable about the context of chemsex (motives for using, contributing factors, potential pitfalls). This would allow caregivers to create a culturally sensitive and effective service for MSM that develop problems on account of chemsex. 'Culturally sensitive' means the caregiver refrains from automatically considering chemsex a problem. By framing chemsex more sensitively and intelligently, healthcare providers would be able to provide a service that better reflects and fits the lifestyle and experiences of MSM, who would in turn perceive it as more approachable, making them more inclined to seek help sooner.*

The interviews in this report suggest that overstepping one's sexual boundaries is invariably considered a favourable effect of using crystal meth. In fact, it's often the very overstepping of boundaries with respect to using drugs that enables the men to experience a sense of belonging and community. Thus a number of respondents stated that chemsex fulfils the need for connection, intimacy, belonging and contact with like-minded people, and helps them to overcome isolation. At the same time they noted that men in this setting sometimes had a tendency towards (sexual) egotism, which ends up thwarting that desired experience of intimacy and connectedness. Strengthening these men's feelings of social inclusion would be a good starting point for intervention.

The respondents who were experiencing a loss of control and who found themselves socially adrift were often leading less stable lives. Most of them were not (or no longer) employed and didn't (or no longer) had strong social networks to provide support. These men were suffering from melancholia, anxiety and loneliness, and felt disconnected from society. Approximately one-third of the respondents had experienced some form of rejection during their youth on account of their homosexuality, by others in their immediate environment but sometimes by themselves in the form of self-hatred. Some of the respondents only came out of the closet in their thirties or forties. The syndemie theory may provide an explanatory theoretical framework for social drift (see *Chapter 3*). This theory considers adversities in a person's life, such as social exclusion and internalised homophobia. Adversity can manifest itself at an early age, but can also occur later in life. The syndemie theory assumes that adversity creates a greater risk of depression, stress, sexual abuse, sexual addiction, sexually risky behaviour and drug dependence.

However, syndemie theory researchers are also interested in identifying the characteristics of MSM that exhibit resilience. As such, prevention should focus on strengthening the resilience of gay men in order to reduce the risk of experiencing a loss of control in the event of drug use. The majority of MSM interviewed for this report maintained some degree of self-control, and tried to keep chemsex healthy and enjoyable. This commitment to sexual and mental wellbeing may offer a line of approach to caregivers seeking to help MSM maintain control.

This raises the question of how to assist MSM that have lost control of their drug consumption, and who may also be socially adrift. Instead of seeking medical and/or psychiatric explanations for social drift, explanations that are often reductive in nature, the focus would instead be on strengthening the resilience of MSM. According to researchers in the field of syndemie, reinforcing the client's sense of social connection and integration (for example, by setting up and inviting them to participate in 'peer support' groups) can be effective as a complement to existing therapies that address the underlying problems. This too requires chemsex to be framed in a particular way, whereby the focus is on social and sexual welfare rather than on drug and sex addiction. In so doing the resilience of MSM may be addressed without automatically problematising their drug use.

Recommendation: *Interventions targeting MSM that develop problems on account of chemsex should include the strengthening of social inclusion, for example through peer support groups. Again, this demands that chemsex be framed in a particular way, whereby the focus is on social and sexual welfare rather than on drug and sex addiction. In so doing the resilience of MSM may be addressed without automatically problematising chemsex.*

RECOMMENDATIONS

A list of all the recommendations in this report.

MONITORING

- A new national behavioural study of a broad group of sexually active MSM is required. This study would provide a better understanding of the situation regarding chemsex as well as the information and support needs of MSM that have chemsex.
- We recommend that all municipal health organisations for preventive healthcare always fill out the currently optional SOAP question about drug use during every MSM visit to an STI clinic. This would allow for a better understanding of the (regional) trends in drug use among MSM and establish the relationship between the use of specific drugs and STI transmission.
- In view of the fact that slamming might also be gaining ground in the Netherlands, the RIVM should include an enquiry about intravenous administration and the rectal insertion of drugs in the optional SOAP question about drug use.
- Better monitoring of drug trends is vital. We specifically suggest funding a national monitoring mechanism that by triangulating the different (local) sources and monitoring what's happening online can create an early-detection system for spotting new trends in drug use.
- We recommend that all drug-treatment institutions that enter information into LADIS, as well as the emergency services affiliated to the Trimbos Institute's national Monitor Drug Incidents (MDI), record crystal meth use in a separate category.
- We recommend that all HIV clinicians and HIV counsellors with patients who display poor adherence to treatment enquire in a judgement-free manner about their clients' drug use and ask explicit questions about which specific drugs they are taking and in what way they administer them. It is further recommended that the HIV Monitoring Foundation (SHM) keep a record of all virological failure resulting from drug use and note all cases of the development of resistance to treatment

PREVENTION

- To provide better preventative measures that reflect the reality of MSM that have chemsex, choose to do so without condoms and yet would like to minimise the risk of contracting HIV, it is vital that we provide instructive information about the benefits and drawbacks of the different risk-reduction strategies. This information should highlight, among other things, that the mutual exchange of information about everyone's HIV status, HIV and STI testing habits and viral load is vital if the participants wish to implement the risk-reduction strategies successfully.
- A much greater effort needs to be made to get instructive information about hepatitis C into the hands of men who use crystal meth and/or slam, and who therefore are at greater risk of contracting hepatitis C. HIV-negative men who engage in group sex under the influence of crystal meth or who slam drugs should be given a realistic picture of the risks they run with respect to hepatitis C, particularly in relation to intravenous drug use.
- In order to gather and disseminate instructive information on smoking crystal meth, an investigation must be carried out to distinguish the less harmful techniques from the harmful ones, and the risks posed by sharing pipes must be clarified.
- There is a vital need for highly instructive Dutch-language harm-reduction information on crystal meth and chemsex that connects with the target audience. This material should provide information about the prevention of potential problems and about what to do in the event of a drug-related incident, among other things.

HEALTHCARE

- The basic understanding among professionals with regard to crystal meth and chemsex must be enriched without delay to improve the first contact of MSM with GPs and the people who conduct intakes at drug-treatment facilities.
- Consideration should be given without delay to the development of an accessible form of care provision in the area of drug use and sexual health for MSM in order to make effective referral (to addiction clinics, for instance) possible. This could be created through accessible, integrated facilities (co-located care), such as a joint venture between STI clinics and drug prevention and/or drug support services.
- In addition to the need for caregivers in institutions for mental health and in drug-treatment facilities to be well informed about the drugs MSM use during chemsex, they also need to be knowledgeable about the context of chemsex (motives for using, contributing factors, potential pitfalls). This would allow caregivers to create a culturally sensitive and effective service for MSM that develop problems on account of chemsex. 'Culturally sensitive' means the caregiver refrains from automatically considering chemsex a problem. By framing chemsex more sensitively and intelligently, healthcare providers would be able to provide a service that better reflects and fits the lifestyle and experiences of the target audience, who would in turn perceive it as more approachable, making them more inclined to seek help sooner.
- Interventions targeting MSM that develop problems on account of chemsex should include the strengthening of social inclusion, for example through peer support groups. Again, this demands that chemsex be framed in a particular way, whereby the focus is on social and sexual welfare rather than on drug and sex addiction. In so doing the resilience of MSM may be addressed without automatically problematising chemsex.



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