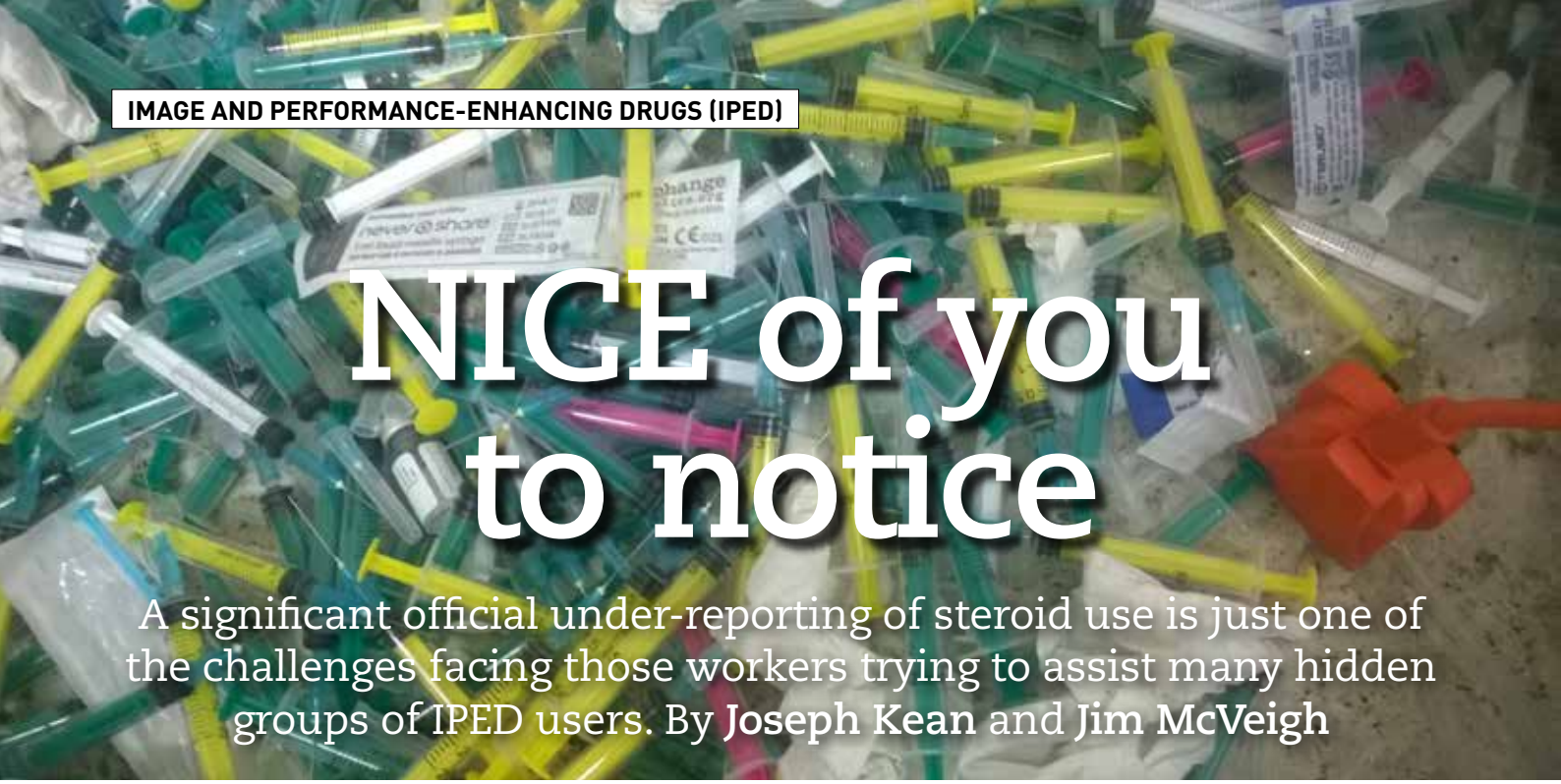

NICE of you to notice

A significant official under-reporting of steroid use is just one of the challenges facing those workers trying to assist many hidden groups of IPED users. By **Joseph Kean** and **Jim McVeigh**

For anyone who trains in a gym and has been brave enough to venture into the free weights area where the monsters live, you will know that steroid users are everywhere. The Crime Survey for England and Wales has steroid prevalence at 50-70,000. But we know (and have hard data to support it) that in areas which have been proactive in service provision for some time, the numbers of registered steroid users usually accounts for somewhere in the region of 1 to 1.45% of that population (1600 registered users in a city or town of 110,000 for example).

Although, a crude calculation, if you extrapolate that figure across England and Wales it is easy to see that the official estimate is a long way off; even adding a zero would still not come close enough to the numbers those of us on the frontline suspect.

National media are quick to mock the shallow 'Geordie Shore-esque' qualities of the user with their shiny hairless bodies and too tight tops, yet we only need to turn a page or two or move along the shelf in WH Smiths to find a plethora of 'mass freaken muscle' articles and images of men close to deformity to which we should apparently all aspire to. The affliction of unachievable goals pushed in your face was previously only for women; but no more. Now the pressure is on for men everywhere you look.

So where are we with research into the health consequence of steroid use? Studies to explore steroid use are now appearing more frequently and appear also to be targeting the areas that we actually want to know about. Until these happen however, there are currently still only a few areas where we really know the effects of steroids.

Firstly, that blood borne viruses are present in steroid users, and at levels now alarmingly comparable with opiate users. Last year's paper by Hope and colleagues published in the *British Medical Journal Open*, showed that 1 in 18 steroid and IPED injectors have been exposed to hepatitis C, 1 in 11 have ever been exposed to hepatitis B and 1 in 65 have HIV. Data published by PHE earlier this year show even higher levels of HIV amongst injectors of anabolic steroids and associated drugs

Secondly, that long term steroid use damages the heart: in November 2013, Harrison Pope and colleagues published evidence from the first ever study on long term steroid users which indicated, that long term use negatively impacts on the heart and in particular that steroids are "associated with premature coronary artery disease and systolic and diastolic left ventricular dysfunction".

For years now we have been seeing local and high profile cases of steroid users dying from heart related disease at ridiculously young ages and this makes complete sense if you take into account the effect of the drugs themselves combined with associated activities that also stress the heart such as fasting and dehydrating.

Thirdly, unlike years ago, when well connected users could obtain genuine products, there are virtually no legitimate pharmaceuticals available to users. The only suppliers now are underground laboratories. Some products will contain the correct ingredients, with minimal adulteration and approximating the stated strength. Some won't and some won't even come close.

So with the research spelling out the risks, why are we so behind with service delivery? There is some progress. Practitioners in services now have a relatively useful tool in the guise of the recent NICE Guidance (PH52 Update) which, for the first time ever, is pushing for appropriate services for this long-neglected group.

Since the publication of the guidance in March however, it appears the news has only trickled down to the occasional commissioner and everyone seems to be waiting for everyone else to do something. Geographically, the North of England (together with Scotland and Wales) appear, in the main, to lead the way in relation to interventions and service provision. Requests for specialist steroid training delivery for staff in services are at an all time high and at most needle exchanges, steroid users are more than happy to engage with harm reduction staff.

However, there are still totally unacceptable situations among a population that still do not see themselves as drug users:

The picture (above) was taken in a

gym; it's a sink in the bathroom area where numerous injections take place every day. The cord is from a garden machine that had been used to 'suck up' large volumes of discarded needles and debris within the gym.

You would hope that people in gyms like this would have access to some form of decent harm reduction advice or drug services? Well, they don't.

Twenty years ago, a conference which acknowledged that caring for steroid users should now be part of mainstream drug work, outlined the adverse effects of high dosage anabolic steroids, the perils of the illicit steroid market and the development of appropriate interventions for steroid users.

Now, the poly-pharmacy is far more complex and fast-moving than could ever have been imagined back then. We have a much more diffuse population of users in every demographic: ex heroin and crack users wanting to no longer appear malnourished and pasty skinned, East European influxes with a lengthy historic culture of strength sports, Asian men with already existing cultural image consciousness, female users of anabolic agents combined with melanotan and dietary agents, to name just a few of the new groups. We are a long way from evidenced based best-practice. But this should not be a barrier to delivering interventions based on sound harm reduction theory, evaluating their effectiveness and, most importantly, engaging and communicating with service users and potential service users.

Percentage of NSP clients using IPEDs in the North of England-2014

Area	Percentage
Middlesbrough	67
Kirklees	60
Sheffield	62
Newcastle	52
Sunderland	60
Bradford	41
Halton	86
Liverpool	83
Sefton	43
St. Helens	34
Warrington	86
Wirral	77
Manchester	60
Bolton	52

Data provided by NSP service providers/ managers via pied-forum@googlegroups.com (Kimergård & McVeigh, 2014)

YOU WOULD HOPE THAT PEOPLE IN GYMS...WOULD HAVE ACCESS TO SOME FORM OF DECENT HARM REDUCTION ADVICE OR DRUG SERVICES? WELL, THEY DON'T

There are many examples of good work out there; Yorkshire and Humber have a Regional Steroid and IPED Reference Group and Workers Forum with over 30 people and every district represented. There is a National Forum that has recently formalised a core group and board (but has an uneven distribution of membership across the United Kingdom) and NICE have only recently showcased an excellent piece of work delivered by the Cambridge Centre in Scarborough.

So the message to policy makers, commissioners, service managers and practitioners is that there are huge numbers of steroid users accessing needle exchanges – and there are a whole lot more of them out there who are not. In needle exchanges right across the north of England (where data are available) the majority of clients are not users of heroin and definitely not novel psychoactive substances, but are injectors of drugs for which there has been virtually no investment in research or service development in the last 20 years.

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Case Study: The Cambridge Centre, Scarborough

Staff at the Cambridge Centre's needle and syringe exchange programme (NSP) were aware that there was a significant and growing number of IPED injectors outside of treatment. Through local discussion and with key national partners, including The Bridge Project and Exchange Supplies, it was agreed that we needed to set up a peer exchange scheme within the local gym and facilitate a Cambridge Centre worker-led 'gym clinic 'to provide the more sophisticated interventions such as BBV (Blood Borne Virus) testing and educated harm reduction IPED information.

The Cambridge Centre has facilitated peer exchange in the past to IDU's (injecting drug users), however it was clear that extra training for staff and peer's needed to be arranged specifically for IPED.

Staff from both the Cambridge Centre and the local gym attended comprehensive training on IPEDs. This enabled us to identify gaps in knowledge and practice and up skill all who attended, whilst also establishing a relationship with the gym staff and supporting them throughout. The relationship with the gym was further enhanced by the Cambridge Centre team manager and dedicated IPED workers visiting the gym to liaise with gym staff building confidence and trust whilst establishing professional respect.

The gym owner made a generous offer to allow the Cambridge Centre's mobile needle exchange worker to use facilities at the gym, to foster a working relationship with gym staff and clients. The clinic would take place weekly in situ with the mobile needle exchange worker being the main contact between the staff and the Cambridge Centre.

It was decided that the 'gym clinic worker' could offer interventions specifically around:

- BBV dry blood spot screening for HIV/ AIDS HCV/HBV;
- Safer injecting work, site rotation, appropriate site injection and paraphernalia use;
- Harm reduction advice;
- Referral into wound care services at the Cambridge Centre;
- Referral into sexual health services at the Cambridge Centre and distribution of condoms.

The gym peer exchange scheme has been running for a number of weeks. We have seen an uptake in NSP from a hard to engage client group. The owner of the gym (who from the start was far sighted enough to embrace a novel way of facilitating harm reduction) has felt confident and supported enough to promote the service on his company's social media sites, through leaflets provided by the Cambridge Centre and by word of mouth at the gym itself.