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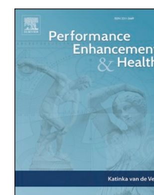

Response to commentary

Coaching the drug coach: An invited commentary in response to Gibbs et al. anabolics coaching: Emic harm reduction or a public health concern?

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It is well established that performance and image enhancing drugs (PIEDs), such as anabolic-androgenic steroids (AAS), are effective in increasing muscle mass and strength. For a variety of reasons there has been an increase in non-medical AAS use in recent decades, and that use has evolved beyond just the small groups where it was previously confined (Dunn et al., 2022; Piatkowski et al., 2021). With that increased and expanded usage comes an industry that supports that use - coaching. As Gibbs et al., have identified, these are intricate culturally-embedded networks reliant on peers who, often, are those with body and social capital. These established members of the community straddle roles in mentoring and harm reduction, as well as acting as suppliers. Coaches are even more uniquely positioned at the intersection between providing exercise prescription and nutrition advice (including legal supplements), as well as providing advice around PIED use through mentorship via lived experience. Although previously restricted to face-to-face instances, this type of relationship has extended into online spaces in line with proliferation of online markets (van de Ven et al., 2020). In the same way that these markets have been found to offer a pseudo-protective effect to AAS consumers (Dunn & Piatkowski, 2021), online coaching provides (purported) 24/7 access to mentors with cited lived experience who are able to manage harms as they arise.

This is a rapidly emerging space in the UK and based on our observations, something which is increasing in Australia also. For PIED consumers 'down under', a narrative is also emerging which is supportive of Gibbs et al.,'s work regarding the spread of online drug coaching markets and the consequences they can have for the community. Strength coaches in this space have expressed that there are drug coaches giving 'bad advice steroid wise' and have been active in managing the health of these individuals who prescribed 'ridiculous cycles'.

The Authors put forward an interesting discussion around the pragmatic solution which drug coaches represent; however, the question remains: how are 'good' and 'bad' coaches defined? This distinction is particularly important given the disparity between evidence-based practice for hormonal therapies and what current data demonstrates PIED consumers are doing. Anecdotal and other evidence indicates that some coaches are 'prescribing' inappropriate substances at levels which are concerning, e.g., in excess of 75 mg of Trenbolone per week alongside other compounds for a novice female lifter.

In meeting the needs of the drug coaches, who have the potential to act as peer-conduits, community engagement with consumers in Queensland and Victoria has shown us that increasing awareness alongside education and substance literacy may be a viable direction. Coaches, linked in with TP and MD, have been requesting better education in the interest of assisting their clients with harm reduction. For example, anecdotal evidence points to key knowledge areas being the legalities around PIED use, testing quality and purity of substances, and the differences in approach for women and men.

This is an exciting new space which Gibbs and colleagues have adequately identified as one which requires further research and debate. Linkage between emic harm reduction and the public health response would likely benefit from being driven research. As researchers in this space, we stay active in community engagement via consultation with

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both the end-users (PIED consumers and coaches) and the workforce and organisations (needle service providers [NSPs] and general practice clinics) who work at the coalface with this client group, through podcasts, consultation, and regular discussion via various platforms. We believe, through preliminary discussions with drug coaches, there certainly is space for more active linkage.

But how do we reach the 'bad' coaches? The short answer is we may not. The responsible coaches participating in ongoing research in the Australian context have suggested that financial motivations may be problematic – a view shared by participants interviewed by Gibbs and colleagues. To compound the issue further, the advent of online drug coaching means that these people are oftentimes on separate continents. We believe the potential to circumvent these harms lies in stronger alignment with peer-frameworks embedded at the level of those working at the coalface - NSPs. Leveraging the lived-experience of persons who inject drugs (PWIDs) is a space where intramuscular (IM) use lags far behind intravenous (IV) use for peer-led harm reduction (Piatkowski et al., 2022). For example, peer-led programs have demonstrated success for harm reduction, such as for HIV (Walsh et al., 2009) and hepatitis (Henderson et al., 2017) prevention, through outreach and on-site initiatives provided for IV users (Walsh et al., 2009). Developing structured peer-led frameworks and accompanying policy which is tailored for PIED consumers provides a reliable point-of-call which will also be more localised. This type of approach is quickly scalable to a state-wide and national level for Australia, with clear potential for replication internationally.

This is a space in which researchers, clinicians and other allied health workers, consumers, and coaches themselves may be able to collaborate and produce translatable research of impact.

CRediT authorship contribution statement

Tim Piatkowski: Conceptualization, Writing – review & editing. **Matthew Dunn:** Conceptualization, Writing – review & editing.

Declaration of Competing Interest

None to declare.

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