Chemsex
in European cities

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Europe at the risk of chemsex

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In every metropolis, in every region of Europe, chemsex is present.
It only involves a minority, but it's more deeply rooted than it was five years ago (*Swaps* nº 92-93). Responses differ from one country to another, from one NGO, community or state experience to another. This is the purpose of the survey that *Swaps* conducted in Amsterdam, Barcelona, Berlin, Brussels, Lisbon, London, Paris and Zurich. It is not intended to be exhaustive, but rather to share experiences.

The survey was carried out with support from the City of Paris Municipal Services and the Inter-ministerial Mission for Combating Drugs and Addictive Behaviour (MILDECA).
Chemsex is a social phenomenon, a set of practices involving sex and the use of drugs, as well as a way to meet for men who like men. The definition of chemsex: the sexual intentionality of synthetic drug use. The drugs heighten sexual sensations, relationships and pleasure in a way that is reported to be unequalled, exceptional and different. The products are also constantly renewed thanks to the "adaptive genius" of a number of shadowy chemists and the commercial capacity of traffickers, aided by social networks and dating apps.
It's hard to say whether it's supply or demand that is driving the game.
Chemsex allows people to meet on a large scale and with products gives them the opportunity to get together with fellow beings, but also the young with the not so young, the handsome with the less handsome, the wealthy with the financially fragile, the successful with the less successful, those who want it and those who are less interested, raising the central question of consent under the influence of products. It is a new form of sexuality based on dating apps, it is present all over Europe and based on supplying drugs thanks to the Internet and the uberisation of delivery, marginalising gay-friendly establishments even further. It comes at a time when the risk with regard to one's sexuality – and life itself – has eased thanks to HIV treatment and PrEP, and removes much of the dark cloud of HIV as a deterrent.

Chemsex can be an exhilarating experience that some people control and handle by managing the troublesome aspects, the so-called “happy chemsexers”. The fact is that these products that give you the thrills and spills you’re looking for also have negative psychological, psychic and physical effects, that can lead to social isolation, a slippage of personal finances, a possible move away from studies or work, or from close relationships, and addiction when you can’t get out of it any more. Accidents and fatal overdoses, such as the G-Hole, highlight the extreme risk posed by products that you are not familiar with, that you take too much of, or without having someone close to you who you can call for help in the event of an overdose emergency or an accident.
Not to mention the infection risks, from HIV and HCV to complications related to injecting (“slam”) and the negative psychiatric repercussions beyond dependence.
The relational, sexual and addictive dimensions of chemsex also meet up with the psychological fragility of MSM, the result of the suffering caused by heteronormativity and the psychological and physical assaults suffered very early in life, which still manifest themselves in brutal or insidious forms.
But gays are used to collectively taking matters into their own hands: the long-standing struggle for gay pride, the experience of fighting to be the primary actors in the response to AIDS, the conquest of harm reduction for drug users. They use it here for their regulation of chemsex in different ways: self-regulation, collective information, self-support, developing new responses or borrowing from related fields. For some, preventing chemsex is “mission impossible”. The beautiful dragon is in the room, good and wanted. We haven’t really been any more successful with other products.
Research is underway, particularly in France under the auspices of the National Agency for Research on AIDS and Emerging Infectious Diseases (ANRS-MIE), the French National Institute of Health and Medical Research (Inserm) and the NGO Aides.
The community response is a Harm & Risk Reduction strategy which has yet to be invented and organised out in the field, drawing on the experience gained with HIV, using social networks and proposing information about the products: drug testing, prevention of the risks associated with injecting, optimising prevention and treatment of STIs and HIV, being able to respond to life-threatening emergencies, without forgetting to remind all the actors about the norms of consent. It also means raising awareness and mobilising addiction and sexology professionals and other sexual health stakeholders. It also means proposing activities to combat the isolation and loneliness that the real/false chemsex encounters do not really resolve.
These elements are present in community responses, but not in all of them. They vary from country to country and from community to community, so we need to enrich them with the best of each, which is the aim of this issue of *Swaps*.
What can addictologists and sexologists do? Listen, reassure, advise and, classically, treat, when the person is overwhelmed by suffering or senses the distress and isolation that chemsex brings when it becomes “chemchems”.
What can public authorities do? Facilitate and allow the community response to get moving, support it institutionally and on a long-term basis, and protect it from a purely repressive top-down authoritarian intervention.

Chemsex: the need to adapt responses

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Combining "chemicals" and "sex", the word "chemsex" refers to the use of psychoactive substances in sexual contexts. The term became popular in the gay community in the late 2000s, particularly in the UK and the US, and took off in France around 2010. Along with chemsex, "slamming" appeared: drug injecting, in the same sexual context, a practice concerning a minority of chemsexers, but with significant health implications. The present article gives a non-exhaustive description of the historical and scientific data available so far, as well as pending research questions.

A phenomenon appearing in the early 2000s within the gay community

The chemsex phenomenon refers to the use of drugs specifically for sexual purposes. It was defined by David Stuart, an activist for the rights of MSM (men who have sex with men), as a gay cultural phenomenon (Stuart, 2016,[1]). Similar practices existed well before the word "chemsex" appeared, but this particular combination of drugs and sex presents certain specificities. Chemsex emerged in the 2000s among MSM using psychoactive substances such as cathinones (mephedrone, 3-MMC, 4-MMC, 3-CMC, etc.), GHB/GBL or methamphetamine (crystal, tina) in sexual contexts, mostly in groups and for extended sessions.

Already in 2012, *Swaps* devoted a whole issue, n°67, to cathinones (https://bit.ly/3KQtZar). It took until September 2021 for the then Health Minister, Olivier Véran, to mandate a mission, led by Professor Amine Benyamina, to produce the first national report on chemsex[2]. This report indicates that drugs are mainly used in this context to initiate, facilitate, prolong or improve sexual relationships, performance, and stamina thanks to the psychoactive effects of the substances being used.

Field actors participating in the Chemsex forum[3] defined chemsex as substance-use by gay and bisexual men, and trans and non-binary people, in sexual contexts. It was seen to be linked to social attitudes towards LGBTQ+ people and gay sexuality, and to the trauma caused by the HIV/AIDS epidemic, but also to peer pressure, to the importance of ritualised activities, to the gay cruising culture, and to new technologies, particularly dating apps with geolocation.

Complex epidemiology

Scientific research published on the subject shows how chemsex has been spreading in many countries (Blomquist et al., 2020; Bourne et al., 2015; Frankis et al., 2018; Herrijgers et al., 2020). The first studies, mainly in the United States and the UK, documented a series of complications related to chemsex: somatic problems and infections (HIV, HCV, STIs, abscesses, vein damage, overdosing), psychological problems (drug-use disorders, self-esteem) and social issues (job loss, isolation) (Halkitis et al., 2001; Mansergh et al., 2006; Ruf et al.,

[1] *In memory of David Stuart from the 56 Dean Street Sexual Health Clinic in London, an untiring activist and social worker. He was the first to develop a website with information about chemsex and is believed to have coined the term «chemsex.» He passed away suddenly on January 12, 2022, and is rightly honoured as an international expert (https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(22)00388-9.pdf).*

[2] *Gilles Pialoux was a member of the Benyamina mission; he is a member of the ANRS-MIE working group chaired by Perrine Roux.*

[3] *"A call to action for effective responses to problematic chemsex", a position paper by participants of the second Chemsex Forum, Berlin, 2018.*

Figure 1. Eras study: sexuality characteristics / Annie Velter, SPF 2024

Number of male partners in the last 6 months	PrEP users n = 3 278 -51%	not PrEP users n = 3 161 -49%	p
2 - 5 partners	17%	47%	p<0,001
6 - 10 partners	27%	27%	
More than 10 partners	56%	26%	
Has practised Chemsex in the last 6 months	29%	14%	

2006; Rusch et al., 2004). Following the Apaches study, published in 2018 (see *Swaps* nº92-93, https://bit.ly/4ctbsgh), research began focussing on the sexual and emotional complications linked to chemsex, which have a major impact on users.

More recent studies carried out during the COVID-19 pandemic suggest this period had a detrimental impact on chemsexers (Roux et al., 2022; Santos et al., 2021, Cheerlock study, 2023,[4]), particularly with regard to accessing screening and prevention, including PrEP.

A 2019 meta-analysis (Maxwell 2019) attempted to establish an order of magnitude of chemsex prevalence (in the United States and Western Europe) among MSM. This analysis of 38 studies concluded it is practised by 3 to 29% of MSM. The proportion could reach 17 to 27% of sexual health centre users in the US and up to almost a third (29%) of MSM using dating apps with geolocation. One of the few multicentre studies to measure the prevalence of chemsex in France was conducted in 2015 (Trouiller et al., 2020). It found that 20,9% of the 2,610 MSM who attended community venues and events in five major cities in France engaged in chemsex at least once a year. 3.1% reported having already injected substances (slamming). In the 2023 ERAS study, 29% of the 3,278 PrEP users declared having engaged in chemsex in the past six months, versus 14% of the 3,161 MSM who did not use PrEP (p<0,001) (see figure 1).

It is even more complicated to gauge how chemsex has developed over time and geographically. One of the rare longitudinal studies carried out in Switzerland with an HIV-positive population found chemsex-related drug use (GHB and methamphetamine) had tripled among MSM between 2007 and 2017 (Hampel 2020). Regarding geography, in 2010, the European MSM Internet Survey (EMIS) recruited 174,209 men from 38 countries to answer an anonymous online questionnaire in 25 languages. It compared 44 cities. The data provided by 55,446 MSM showed that in the four preceding weeks, the cities where chemsex was most practised were Brighton (16.3%), Manchester (15.5%), London (13.2%), Amsterdam (11.2%), Barcelona (7.9%), Zurich (7.0%), and Berlin (5.3%).

Also, chemsex does not necessarily take place in cities. Airbnb rentals and dating apps mean sessions can be organised anywhere (Kennedy 2021). Prevalence studies suffer from a lack of consistent definitions, particularly with regard to the substances being used (some include alcohol, erection stimulants and poppers) and chronology (some will date the last intercourse, others will take into account the previous three months etc.).

Chemsex: shifting scenes, substances and practices

Reacting to feedback from the field, in the 2010s several scientific works began investigating the motivations underlying chemsex and, especially, the diversity of practices. The Apaches and PaacX surveys showed that people who engage in chemsex will do so in different ways, amongst themselves and over time. Chemsex is also described as somewhere where you can let yourself go and feel pleasure. This aspect, often overlooked in

[4] https://pubmed.ncbi.nlm.nih.gov/36562613/

studies on drug use (Schroeder et al., 2022), could provide insight into drugs and sexuality, risk perception and the lives of people who engage in these practices. Chemsex allows gay people to break free from their physical and psychological image and, liberated from norms, to find partners more easily. It allows participants to feel they belong to a group, which can counteract loneliness. All of these aspects need to be taken into account when providing care for users.

Chemsex is often associated with a set of practices in specific environments: an almost systematic use of dating apps, combining different drugs and methods (sniffing, bumping, IV/slamming, inhalation), group sex, more intense sexual acts (sex toys, fisting), usually in private settings or sex clubs. Practices evolve and may follow trends, as evidenced by the various substances used in different countries and the speed at which one substance can replace another in just a few years. Chemsex has been the object of attention since the late 2000s because sessions can also involve traumatic experiences, such as sexual violence, overdoses, vein damage, psychological trauma and accidents that require medical attention or that even result in death. Many of these deaths are linked to GHB/GBL, a drug that is widely used in this context and can cause users to lose consciousness and have respiratory depression. Social and professional disengagement are regularly reported (Barbier, 2017).

Media attention and the risk of discrimination

The first articles in French mainstream press after the first lockdown gave alarming reports about chemsex, citing states of distress, overdoses and serious health complications. Headlines reflected this growing concern: "Paris is worried about the chemsex phenomenon, spreading across the capital in a big way", "Chemsex is becoming worryingly common amongst heterosexuals"and "Chemsex in Lille: it's on the rise and social workers are concerned." The Pierre Palmade affair was a tragic blow, linking chemsex, famous figures, the gay community and a fatal accident. The media quickly and easily made these connections, producing discriminatory narratives that have had detrimental effects on people's health and access to care and harm reduction services.

According to daily newspaper *Libération*, the event was a "perfect storm" for scandal, combining fame, drugs, sex and an incident that could be endlessly told. French comedian Pierre Palmade caused a car accident on February 10th 2023 in which a child was killed. This event was the object of media frenzy for the rest of the month. According to data collected by media monitoring platform Tagaday for Libération, the "Pierre Palmade affair" was mentioned 29,905 times by media (internet, radio, TV, and print). This amounts to an average 1,573 articles or reports per day since February 10th: about one in 90 articles. This, for a subject, chemsex, that had hardly ever been covered before this celebrity scandal. Comparatively speaking, the Palmade affair received approximately a quarter of the media coverage given to the war in Ukraine (127,389 mentions), which at the time was marking the first anniversary of Russia's invasion on February 24th 2022.

From health risks to legal liability

In France, over 200 psychoactive substances are banned by the decree of February 22nd 1990 listing all substances classified as narcotics. Cathinones are on the list, including the most commonly used molecule in that category, 3-MMC. Laboratories producing them are generally abroad (Le Dévédec 2022) and the substances on the market are often different to those expected (Willeman, 2023, HRJ). When the Netherlands banned 3-MMC, an even more toxic substance, 3-CMC, appeared on the market. It has more intense psychoactive effects and is more harmful, particularly at the injection site.

The effects of these substances, especially the combination of 3-MMC and GHB/GBL and the risks they cause both for those using them and for people in contact with the users, are important issues. An overdose can be fatal, and consent is difficult to assess for all participants. It is crucial for people to be informed and to provide appropriate responses.

Legally, explains Le Dévédec, consent is a sensitive subject, because "the difficulty with chemsex is that it's very complicated to know what a victim consented to, what they did not consent to, and how aware partners could be of both, particularly when the participants' judgement is impaired, and they can even experience memory loss, under the effect of certain highly amnesic substances". "For these reasons, impaired judgement can be applied to chemsexers, whether victims or accused, under Article 122-1 of the Penal Code, which states in its first paragraph that 'a person is not criminally responsible if, at the time of the events, they were suffering from a psychic or neuropsychic disorder that abolished their judgement or control over their actions'" (Le Dévédec, 2022).

A recent study directed by the French Society of Analytical Toxicology (SFTA, https://www.sfta.org/) inventoried the chemsex cases reported by 19 toxicology laboratories in France between 2018 and 2023. In all, 232 chemsex

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cases were reported in 14 different regions. Ninety cases of intoxication (39%) were reported, with symptoms such as coma, loss of consciousness, agitation, and tachycardia. Fifty deaths (15%) were recorded. Also, 61 cases of substance use disorders indicating drug addiction and 18 cases of non-consensual sex were reported[5].

A British publication identified 61 deaths associated with GHB, 184 deaths associated with cocaine and 83 deaths associated with MDMA in London between 2011 and 2015. The number of deaths associated with GHB detected in 2015 increased by 119% compared to 2014 (Hockenhull J, 2017).

To summarise, we have limited data about consent, overdoses and the appropriate ways to respond to these issues. Only cohort studies could provide adequate information.

Mental health and access to care

Whatever their relation to chemsex, and the level of risks their practices involve, chemsexers have different and evolving health needs that require adapted care (Blanchette et al., 2023). With regard to these issues, chemsexers seem to have developed their own specific harm reduction strategies, healthcare circuits and forms of peer solidarity. These are still insufficiently documented but demonstrate users' desire to take care of themselves rather than to fall into a state of panic characterised by reckless behaviour.

Many articles describe the psychological vulnerabilities of MSM who engage in chemsex or the complications associated with chemsex (Hibbert et al., 2019), without being able to identify the cause (whether it be pre-existing difficulties or the consequences of chemsex itself). Psychiatric disorders can predate substance use, such as attention deficit hyperactivity disorder (ADHD) or past traumas (PTSD) from childhood or adolescence, and be related or not to homosexuality (Bohn et al., 2020). Some MSM who take risks seem to have suffered from emotional neglect, to have low self-esteem, relational problems, and sometimes internalised homophobia. Finally, substance use disorders linked to chemsex drugs (cathinones, GHB/GBL) are experienced by many MSM who partake in chemsex, as well as behavioural addictions (phones, apps, social networks) (Zou and Fan, 2017).

There is little data about access to care and prevention services for all MSM who engage in chemsex (except for MSM with access to PrEP, mostly in urban areas). Little is known concerning the extent to which these services are used, or their impact (in terms of behaviour change). This depends on many structural factors (geographical accessibility, organisation, visibility, adequacy, community participation) or individual factors (cognitive, cultural or financial resources) (Sousa et al., 2020). Data about available care and the way MSM chemsexers make use of it is important, since it can influence chemsex trajectories.

An important part of harm reduction is to better understand the role drugs play in sexuality, for instance people allowing themselves to engage in practices they would not have undertaken without drugs (ranging from accessing tenderness to sex that excludes any form of connection with others) and better understanding the limits of having sex when under the influence of drugs (from sought-after disinhibition, to non-consent) (Gaissad and Velter, 2019). Questions arise concerning masculine sexuality, in which high-level performance would be mandatory and guide people's choice in sexual practices. Using psychoactive substances could lead MSM to a sexuality that becomes impossible without drugs, and sometimes causes sexual disorders resulting in impotence (erection difficulties, anorgasmia, decreased libido; fear of having sex without drugs) and related psychological consequences.

Socio-cultural specificities of chemsex for migrant, trans, young and senior populations

Although the first authors to have written about chemsex acknowledged its specificity as part of gay culture (Stuart, 2019), there is limited data about the role chemsex plays in the social lives of MSM with multiple forms of vulnerability, such as migrant MSM, trans people, young MSM or even elderly MSM. Community associations report that migrant chemsexers often experience compounded vulnerabilities (difficulties with their administrative situations or their access to rights and healthcare, social isolation, psychological problems…). These can increase sexual pressure and limit their ability to choose which sexual practices they engage in. Qualitative surveys also underline the importance of (re)connecting with sexuality for MSM in exile from their country of birth (Mole et al., 2013; Chen, 2023), with chemsex playing a role in this (re)connection. The path towards chemsex and the way it is experienced also depends on an individual's feelings about homosexuality, whether they were part of the LGBT community in their home country, whether they have become part of the community in the host country, and also their approach to STI/HIV prevention and risks (Araújo et al., 2023).

[5] https://www.sciencedirect.com/science/article/abs/pii/S2352007823001488?via%3Dihub

Community organisations and chemsexer testimonies confirm there are trans men and women among chemsex participants. However these populations are underrepresented in quantitative studies on the phenomenon, and there is often too little data for it to be interpreted scientifically. We do know this population is confronted with specific violence issues, particularly transphobic violence, as well as a variety of social vulnerabilities that impact their physical and mental health.

For certain young MSM, entering their sex life can take place particularly rapidly via chemsex (Tan et al., 2021), with the issues of consent and relationships of dominance it comes with. Community organisations indicate there are also chemsexers over 60, with specific vulnerabilities (isolation, poor knowledge of the drugs being used), but also a chemsex experience that can allow them to "rediscover" their sexuality.

The question of chemsex spreading beyond the gay community is still being debated: are heterosexuals getting involved?[6] The controversial French study Sea, Sex and Chems (Cessa, 2021) found, in a population of 1,196 people defining themselves as chemsexers (the list of used substances includes cannabis and alcohol), 73.3% MSM, 16.5% women, 5.4% heterosexual men and 4.2% non-cisgender individuals. A Dutch study also found drug use in sexual contexts within the swinger community (Evers, 2020). However, these practices among heterosexual populations are considered to be sexualised drug use and less intense than among MSM, for whom adapted public health policies are necessary (Hibbert, 2019). To better understand the pathways of the people in question and the determining factors in their lives, and at the same time to include hard-to-reach populations such as non-identifying or migrant MSM, the French national agency for research on infectious diseases (ANRS-MIE, https://anrs.fr/en/) has initiated with its chemsex working group the AC 46, a socio-anthropological study following a cohort of MSM and trans chemsexers. Its aim is to document chemsex practices over a long period of time, to understand the determinants, nuances and dynamics, both in terms of trajectories and their related consequences, with the aim of developing appropriate responses and tools.

[6] *Slate, October 13th 2021, https://www.slate.fr/story/217245/chemsex-democratise-hommes-heteros-cisgenres-inquietant-mst-pratique-sexuelle-drogues*

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A new perspective on chemsex?

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Researchers Soel Real Molina and Gabriel Girard are specialised in LGBTI+ health issues. In this article, they study chemsex from a social science perspective, allowing readers to consider both the various challenges posed by chemsex and a broad range of possible responses – at individual, community and institutional levels.

Chemsex drew unprecedented attention in the French media in early 2023, following the tragic accident involving comedian Pierre Palmade. It was more difficult in this very fraught context to sensitively analyse this evolving, diverse and longstanding phenomenon. And yet, nuance is precisely what is needed to study a practice that cannot be reduced to a series of tragic events. From our point of view, chemsex raises complex social and cultural issues, which a social science perspective, anchored in community-based research procedures, can shed new light upon.

An impossible quest for origins?

The genealogy of the term *chemsex* is now clear: it was first used in England, in the early 2000s. It was David Stuart, an activist and gay outreach worker, who partook in chemsex himself, who popularised the term. Chemsex is thus one of those terms coined by minoritised populations to describe and qualify their practices and identities. Its adoption was neither linear nor homogenous. Although the term was widely used in France, the use of the word "chemsex" was replaced in English-speaking countries by the expression Party'n'Play (PnP). Over the past few years, as chemsex has developed, new names and codes facilitating mutual recognition have appeared, particularly on dating apps. In other words, while "chemsex" is the accepted term in academic, medical and community organisation circles, care must be taken not to "freeze" its meaning or the practices it describes.

Addressing the origins of chemsex also involves recalling the context in which it emerged. Over two decades on, one could easily forget the traumatic impact in the late 1990s and early 2000s of the dark years of the AIDS epidemic. Antiretroviral treatments have been available since 1996, but many people in the gay community are living with HIV and/or have lost friends and lovers to AIDS. They were all relieved when ART became available, but also had to profoundly readjust their plans for the future, their relationship to themselves, to others – and above all to sex. This "post-crisis" context is inseparable from the development of new attitudes towards pleasure and risk-taking. For instance, in the late 1990s, some HIV-positive gay men defended the position of having sex without condoms, which led to lasting controversy about "barebacking". More generally, the approach to prevention changed within gay communities, as the threat posed by AIDS became more remote.

Drug use in sexual contexts did not appear in that period ex nihilo: this is one episode in the long history gay men in all their diversity have had with substance use (Girard et al., 2007). A history laced with public health concerns regarding the role drugs play in homosexual social interactions: about ecstasy in clubs in the 1990s for instance, or the spread of *crystal meth* in North America

in the early 2000s. Chemsex is not a complete novelty, but it does illustrate a new combination of drug use, sex and pleasure for some gay men.

This historical detour reveals how ambiguous it is to talk about a chemsex "crisis". Firstly, the term "crisis" should be more precisely defined: after more than twenty years (David Stuart refers to the term "chemsex" already appearing in 2001!), should we not rather see these practices as well installed, with long-term effects on people's lives and habits? And could the focus on chemsex obscure a more comprehensive understanding of gay men's health determinants?

Chemsex: a revealer of social inequalities

If we shift the focus from the substances themselves – which are too often the only subject of speeches and policies about drugs – what does chemsex reveal? First, with regard to health promotion, it makes no sense to consider just the drug by itself. There is always a convergence between a given substance, a person's life up until then, and the contexts and ways in which the drug is being used.

The issue is more social and political, than individual or psychological. It reminds us of the urgent need to develop non-pathologising approaches to chemsex and to consider communities' capacity to take care of themselves.

In the present case, as we have attempted to illustrate, the new synthetic products are embedded in their socio-historical contexts, following the AIDS crisis, and they concern individuals whose lives are still marked by our societies' structural heterosexism. On this basis, we have to take into account the individual and collective consequences of the systems of domination in question: virilism, homophobia, discrimination against gay men who are considered effeminate, transphobia, and the pressure and violence these men experience throughout their lives, with a profound impact on their social, sexual and mental health. The gay community itself is not exempt: oppression can be reproduced even in community environments that are supposed to be supportive. Gay men using drugs are not all equal in the face of certain consequences of drug use, consequences which can reveal or aggravate pre-existing personal or relational vulnerabilities.

To understand chemsex today, it is essential to bear in mind this complex articulation between individual experience, social interactions and structural factors. Scientific literature emphasises the importance of a syndemic[1] approach, i.e. taking into account the incremental effect on people's health of multiple social vulnerabilities. This means one has to look beyond "risks" or "problematic" drug use. Taking a broader view allows us to take into account the diversity of the challenges associated with chemsex:

– The lingering shadow of the AIDS epidemic, which still weighs on gay men's lives, especially those who lived through the 1980s and 1990s;

– Mental health and the "epidemic" of loneliness that strongly affects gay communities;

– The prevalence of violence (domestic and/or sexual violence) in gay men's lives;

– Discrimination, which still remains all too common in healthcare and, more generally, in public services, when addressing the consequences of chemsex;

– The various groups and inequalities within gay communities, beyond the predominant representation of cis, white and socially integrated individuals.

An approach based solely on health risks and that decontextualises people's lived experiences stops us from having an overall view.

Chemsex seen by social science

The emerging field of "critical chemsex studies" (Møller, Hakim 2023), encourages us to consider chemsex beyond a strictly health-related prism, including to improve community healthcare strategies. Nowadays, chemsex sites are mostly seen as pathogenic, places where somatic and mental illnesses are transmitted. Critical chemsex studies suggest this perception may limit our understanding of the social, cultural and political aspects of chemsex, as well as those related to physicality and pleasure. There is also the risk of re-pathologising gay men, of seeing them as a "perpetually at-risk group" (Gaissad 2017), undisciplined and self-destructive, for whom the only solutions could be abstinence or psychiatry (Schroeder 2022). Conversely, these ethnographic investigations propose a more comprehensive study of what exactly happens during chemsex sessions, the types of social interactions and community care that take place. In doing so, they examine what these practices can reveal about contemporary gay and queer cultures. Certain contributions from the socio-anthropological literature can help us understand:

First, this body of work highlights the function and effects of pleasure in LGBTQ sexualities, identities, and social interactions. By increasing users' pleasure, drugs change sexual scripts, thus transforming both individual subjectivity and relations with others (Race 2017; Gaissad, Velter 2019). In a context of structural homophobia, disinhibition is a central element in homosexual sexualities; and whereas the risk paradigm only sees its negative

[1] *Syndemic means the combination of diseases, and biological and environmental factors that exacerbate the consequences of these diseases for a population. HIV, drug use, and Covid are considered syndemic.*

effects – such as a dreaded lapse in prevention – these studies analyse potential and positive functions: ending isolation, entering sexuality, experimenting, transcending internalised shame (Race et al. 2022). Far from suggesting that there is only pleasure in chemsex, these perspectives provide nuance to the rather rigid divide between addiction and pleasure, between healthy and problematic. What this perspective does suggest is that these realities coexist.

It also encourages us to pay attention to the social and material context: chemsex has profound collective, community-oriented implications. To counter representations of isolated individuals who are all anonymous to each other, Laurent Gaissad (2017) emphasises for instance the importance of gay socio-affective networks for instance, within which self-care and care for others can be observed.

Historically, sexual and gender minorities have developed inventive ways of taking care of each other and having pleasure in safe ways, even in challenging circumstances marred by epidemics and repression. Kane Race sees chemsex scenes as spaces for collective experimentation where participants demonstrate their skill for self-governance: they establish, before and beyond institutional recommendations, "counter-public health" practices (2018). Studies show that people who engage in chemsex have thoughtfully considered and discussed which risks seem most important to them, particularly the risk of addiction, and seek to limit this through what is described as "maintaining a controlled 'loss of control'" (Drysdale 2021).

On a more structural level, the concept of *homonormativity* allows us to understand certain motivations underlying chemsex: according to Sharif Mowlabocus, it represents a form of transgression in a context of gay normalisation and "respectability politics" centered on marriage and legality. It would thus be a subcultural response fueled by the joy and excitement (also) born from being deviant; referring to ideas developed by philosopher Michel Foucault, we could suppose it is a "technique of the self" – a way to build oneself as an individual, resisting orders to assimilate.

Finally, the tools of cultural studies and communication sciences shed light on a crucial aspect: the relation between media and chemsex. First, they allow us to understand the role of digital media (dating apps, pornography) as interfaces that shape encounters and imagination. Moreover, social science research on "moral panic" objectifies how media coverage about chemsex makes certain social figures undesirable and deviant, reduces practices to their most spectacular consequences, polarises the debate on moral issues, and ultimately portrays chemsexers as internal enemies both for society and for their own community. In the name of purported concern for public health and combating HIV, the noisy indignation caused by media coverage of certain "affairs" exacerbates the stigmatisation of those concerned and assigns them to either secrecy or repentance – and always to shame (Gideonse 2016).

Far from being merely theoretical postures, these approaches can help broaden the range of individual, community, and institutional responses to the challenges – including infections and mental health – posed by chemsex.

Exploring empowerment

More than forty years after the AIDS epidemic appeared, addressing the challenges related to chemsex reveals, as we have seen, certain structural and intimate dimensions that still affect homosexuality today. The normalisation of homosexuality may have somewhat overshadowed them at the turn of the 2000s, but they keep resurfacing. The issue is more social and political, than individual or psychological. It reminds us of the urgent need to develop non-pathologising approaches to chemsex and to consider communities' capacity to take care of themselves (Nagington, King 2022 ; Schaffauser 2023). This program is included in the development of community health, inspired by the fight against HIV. It is probably time to draw lessons from it on a larger scale.

This also applies to research, valuing the importance of participatory and community-based approaches (Flores-Aranda et al. 2023). Facing different forms of injustice caused by the production of knowledge itself, opposing moralistic approaches and reductive "danger/pleasure" dichotomies, our studies must give more credit to chemsexers themselves, valuing their knowledge and experiential know-how, to co-develop shared knowledge that can help advocate for access to healthcare and rights rooted in the communities' realities. Today, like yesterday: "Knowledge = Power"!

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Chemsex
is not about morals,
it's about politics

Thierry Schaffauser / STRASS

Writer, sex worker and member of the French sex workers union STRASS, Thierry Schaffauser recalls the history and political issues surrounding chemsex. He is opposed to the moral condemnation of chemsex users and advocates for a prevention policy by and for drug users.*
This text was published in Manifesto XXI on March 3, 2023. It is shared courtesy of Thierry Schaffauser.

On February 10, 2023, comedian Pierre Palmade crashed into a car that was transporting a six-year-old boy, his father and a pregnant woman, who lost her child following the accident. The investigation revealed Palmade was under the influence of cocaine and drug substitution medication, after a chemsex party. Until then, this phenomenon had been confined to LGBTQI+ media, but mainstream and social media snowballed the event, sparking social debate to a backdrop of "moral panic", including within the LGBTQI community. The debate highlighted divisions between a desire for respectability and the affirmation of a distinct sexual culture, along with fears of renewed homophobia. Indeed, the more seasoned observers noted the tragedy in the Pierre Palmade affair provided an opportunity for homophobic rhetoric, under the pretext of condemning drug use.

We can read or hear that gays are dangerous and irresponsible, that, with their disgusting activities, they cause the death of babies and destroy families. We got details about Palmade's sex life, the escort-boys'names, which sex toys were found, how long the sex lasted, which all had nothing to do with the accident. Chemsexers invited to testify have to be repentant and ashamed, or they will be accused of glorifying crime. They are viewed by the "clean gays" as being the cause of homophobia and branded "bad representatives" of the LGBTQI communities. This rejection from within the community seems somewhat a surprise, directed at them, but never, say, at Renaud Camus, who invented the "great replacement" concept. This oddly echoes what has already been said about people who, before chemsexers, also gave homosexuality a bad image: queens, leather fetishists, BDSM communities, puppies, HIV positive people, the gay pride. The list is long. To eradicate homophobia, the aim is not to become exemplary, but to understand the construction of homosexuality as a "deviance".

Drugs and sex: a history of pathologisation

The current process to disqualify chemsexers is reminiscent of what German gay activist physicians did in the 19th century, as they sought to no longer be considered criminals and invented homosexuality as a mental illness. Like other minorities, to no longer be seen as guilty, drug users must present themselves as repentant victims. One trap remains however: being under the control of addiction specialists, like shrinks and sexologists before them, over marginalised bodies. Indeed, the mechanisms of oppression against drug users are not that different from those experienced by homosexuals: pathologisation, medicalisation, being imposed by doctors' knowledge and power, being silenced and dispossessed of their expertise through a process of criminalisation, stigma and shaming; accusations of proselytism and contamination when subjects reject the dominant narrative that turns them into research objects, sick people, or victims of a "condition" that explains their acts.

Conceptualised a little over ten years ago by HIV prevention and sexual health organisations, as AIDS was becoming less prevalent and HIV was considered less of a sanitary crisis and more like a medically controlled chronic illness or simple infection, what had always existed – the use of stimulant and psychoactive drugs to have sex –, became a new public health issue. For ten years, numerous conferences and conventions have tried

* *STRASS: Syndicat du TRAvail Sexuel en France: Union of sex workers in France.*

to define chemsex, a practice that, to be wholly understood, cannot be reduced simply to the use of drugs in a sexual context. Seemingly a new sexual culture has developed within the gay community, in connection with new dating apps, the fact sex scenes have transferred from sex-clubs and outside cruising spots to private locations, the use of treatment to prevent HIV and the impression (whether right or wrong) certain people have that sex has been "medicalised" (cathinones or other products are chemical stimulants that can be combined with Viagra, ART or PrEP). The great orgies of the seventies that we heard about from our elders, nostalgic for "pre-AIDS", are reappearing today, partly with chemsex.

Chemsex: gay business

Chemsex, for many gays, is a new way to socialise. It is about forming a community within the community, taking pleasure together, being together, chatting, using, laughing, having sex, being naked, feeling good together. The disinhibition caused by substance use is an opportunity to further explore one's sexuality, to try new acts, to stage fantasies, to perform sexuality, and, through that, different forms of masculinity, to better understand our subjectivities that are still marked and shaped by homophobia and the trauma of HIV. The quest for intense pleasure is linked to sexual acts, and certain substances are more adapted to either being "active" or "passive", whether the aim is for longer action, a sort of high performance, or to come down gently, with hugs and affection. We could consider drug use has nothing to do with homosexuality ; but those who are a little familiar with the gay community's history and the fight against AIDS know the subject is frequently discussed. When AIDS appeared, some people thought poppers could be causing HIV transmission. In 1997, every gay nightclub was shut down on the pretext drugs were being used there, while straight clubs were left alone. Community mobilisation made it possible for clubs to open again but Act Up's president, Philippe Mangeot, was sentenced in 1998 for an "I love ecstasy" tract that criticised the hypocrisy of gay venue managers and of the 1970 law, and demanded the right to pleasure and a debate about drug legalisation. The fight for homosexual liberation in the 1970s aimed to be revolutionary. FHAR** activists criticised the family institution as a foundation of the capitalist and patriarchal system and advocated for non-reproductive sex to put an end to inheritance as a process of accumulation. The demand for freedom to control one's own body implied being able to put into it whatever gives pleasure, as machines for desiring not producing. But with drugs being criminalised, a determination to subdue unproductive bodies that choose fun over work became evident; work addiction never being considered a public health issue.

** *FHAR : Front homosexuel d'action révolutionnaire: Homosexual Front for Revolutionary Action, a movement formed post 1968.*

To listen and support rather than discipline and punish

If the medical and healthcare approach to chemsex is to be effective, it must adapt to the needs and realities of those concerned. We have known for a long time now that demanding that people stop using rarely works, and that substitution treatments for addiction have shown more convincing results, when they exist for a given substance. Demanding total abstinence from chemsexers by framing any form of use as problematic risks appearing as additional moral condemnation and could erode all trust between users and health systems. Encouraging abstinence was a total failure in the fight against AIDS, as in birth control, the fight against sex work and so many other issues. The "war on drugs" is no exception. It has mainly prevented important information about safer use from being shared, which can be done for legal substances, such as knowing the best doses, which substances not to mix, staying properly hydrated, using equipment that is adapted to the substance and dosage, and can be reused with no risk of infection. Prohibition prevents any effective control of the products' quality, with all the risks of adulterated substances being sold on the black market, as is the current situation, and even leading to the creation of more dangerous derivative products.

To fight addictions too, the most effective approaches involve evaluating, with the users, their consumption habits, how these may become problematic, and, if necessary, how to use less, by changing their behaviour, their relation to parties and gay social life, and their sexual interactions. These approaches, "by and for" key populations, fundamental in community healthcare, make progress and harm reduction possible. Knowledge shared by users has informed medical practice and is the basis of the information that is currently shared and recommended. Chemsexers must therefore be recognized as essential partners and political subjects when developing health policies that concern them. They are the real drug experts, not the doctors on television panels. The recent death of Daniel Defert, who created AIDES in France, reminds us of his founding message about patients being social reformers. The fight against AIDS helped overturn the doctor/patient power dynamic. Let's not forget what we have learned from our struggles. Chemsex is more than a health issue. It is also political and touches on freedom, on our relationship with the state, with institutions, and the biopolitical control of bodies.

The particularities of chemsex in addictology

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Addiction as the loss of the social function of a use or behaviour

From a sociological point of view, substance use, as well as certain non-substance behaviours, are part of complex social rituals that shape group identities[1]. For example, the social use of alcohol brings together and consolidates groups of friends, families and even wider circles such as work colleagues. The same is true of food, particularly in French culture, where meals are important occasions for sharing and hospitality. Despite their illicit nature, this is also true for substances such as cannabis, cocaine and heroin, which are often used in groups, with the same function of sharing and strengthening bonds. This is also true of certain behaviours that do not involve products. Gambling and video games, for example, are often initially part of social rituals where the behaviour helps to cement group identities, the construction of an identity always being based on the groups to which a person belongs.

When it occurs, addiction appears at a much more advanced stage, when drug use has gradually lost its function as a social bond, and the individual has become locked into increasingly solitary and deleterious patterns of use. At this stage, the social environment tends to reject the person who has "lost control", and who is no longer able to respect the implicit codes that define the times when use is appropriate, and the levels of use and impact of the substance that are socially acceptable. It is precisely when individuals are trapped by these invasive and solitary forms of consumption, disconnected from the relational codes within which they learnt how to use the product or how to behave in a particular way, that a diagnosis of addiction can be made, and that recourse to addictology becomes indicated[2].

Such recourse is necessary because, at this stage, the ritualisation around the product or the addictive behaviour evolves all by itself, and invades the other spheres of life, in particular the spheres of social life, i.e. friendships and family life, leisure activities and work. Addiction can thus be seen as the pathologisation of a pleasure-taking ritual that had an initial function as a social bond, a ritual that has gradually become so pervasive in the subject's life that it has become disconnected from its initial relational value.

The principle of addiction applied to chemsex

Chemsex refers to group sexuality, enhanced by the use of certain psychoactive substances, within communities of men who have sex with men (MSM). Although neither group sexuality nor the use of psychoactive substances for sexual enhancement purposes are specific to the MSM community (in which case the term "sexualised use of products" is used), chemsex practices have historically acquired a central identity value within at least part of this community. For some MSM, these practices can, among other things, help build a social bond that gives them a strong sense of belonging to their community. This contributes to the construction of their sexual identity. Chemsex is a communal sexual practice and an identity-building activity and, for some of the youngest members, it is a way of belonging to the "gay" group or integrating into the community.

As described above, for some people, chemsex practices can result in an invasive process and a gradual disconnection between these individuals and the implicit codes that exist for most users, codes that define "normal" practices and are therefore accepted by the group. The individuals concerned by this loss of control gradually become locked into invasive chemsex practices, which spill over into their other spheres of

[1] *Peyron E, Franck N, Labaume L, Rolland B. Psychosocial rehabilitation in addictology. L'Encéphale 2024; 50(1): 91-8.*

[2] *Malandain L, Thibaut F. Chemsex: review of the current literature and treatment guidelines. Current Addiction Reports 2023; 10(3):1-9.*

life and end up isolating them socially[2], sometimes even from a growing number of their own groups of MSM friends, and therefore from their own community. This downward spiral can generate intense psychological distress, leading to psychiatric endangerment, including suicide attempts. But this distress can also be a trigger for these individuals and the people around them who are still there, and this can be the prelude to a request for addiction treatment.

The use of products associated with chemsex without having physical sexual relations is sometimes described as "chemchems". However, this concept is debatable, as users' motivations for consumption may remain sexual in nature and be expressed solely through the use of applications, pornographic videos or virtual sexual relations, even if they are isolated. The fact remains that these practices can be associated with chemsex, presenting increased risks of de-socialisation, intoxication and loss of control. To reduce the risks, we advise against consuming alone, in isolation.

The particularities of addictive disorders in chemsex

Addiction to chemsex is not an officially defined entity, even though addiction to products, particularly psychostimulants, is well described, and the nosographic framework of sexual addiction, or pathological hypersexuality, has also been the subject of structuring studies for many years. But chemsex addiction is not simply the addition of an addiction to psychostimulants and a sexual addiction. This disorder occurs in a specific population, which has experienced a long history of stigmatisation and rejection, and whose acceptance by society is certainly not yet complete.

The onset of a chemsex addiction in an MSM is therefore doubly stigmatising, since it adds the classic stigma of a person suffering from an addiction to the more structurally rooted stigma within the MSM community and its history, even though this "heritage" of stigma can of course be incorporated in very different ways from one person to another. Feelings of distress and rejection can be experienced even more painfully than in other addiction situations, even though it is of course impossible to draw a scale for addictions and each situation is individual.

The psychological impact of addiction and isolation can contribute to the process of spiralling out of control, leading the subject to constantly increase their chemsex practices in order to escape a reality that has become increasingly difficult to bear. Increased use of products can impair sexual performance by creating a dependency on the product. The individual may also become locked into increasingly sadomasochistic sexual practices (e.g. BDSM), which sometimes contribute to feelings of personal devaluation and can increase medical risks, including injuries and risks of infection. Finally, slamming can generate a form of behavioural addiction to injection, which in itself constitutes an additional addictive problem.

Addiction treatment coordinated with other forms of care

Addiction treatment is often coordinated with other disciplines, such as psychiatry, psychology, hepatology, pneumology or infectiology. This is particularly true in the case of chemsex[2]. The addictology units involved in treating people suffering from chemsex addiction cannot therefore work in isolation, and must work in conjunction with infectiology, user organisations, and sometimes psychiatry or sexology professionals. Some addictology units have such resources in-house, or allow partners with such expertise to be involved.

The behavioural aspect of addiction requires essentially psychotherapeutic approaches, and can include a dimension aiming to re-establish a variety of social rituals, possibly through institutional approaches such as day hospitals[1]. Where there is an addiction to substances, particularly psychostimulants, this should be the subject of either a supervised attempt to reduce the drug use or a supervised withdrawal, possibly in a hospital setting. As with all addictive disorders, the treatment plan always depends on the individual's goals, and must evolve as these goals change[1].

If chemsex practices are pursued, prevention and risk reduction measures apply as they do for all users, and include the principles of good knowledge and control of product use, protecting oneself against the risks of infections associated with sexuality or substance use, as well as anticipation of those around in chemsex situations by caring people who are able to act in the event of an overdose[3].

Conclusion

Talking about the risk of addiction in chemsex should not be seen as dissuading people from practising chemsex, just as talking about the risk of addiction to alcohol is not the same as dissuading people from drinking alcohol. The risk factors and the main manifestations of such a condition must be known to the MSM community, in particular to people who practise chemsex and their families. Many associations have set up helplines where problems can be discussed, and partnerships with a local addiction service should enable referrals to be made if necessary, provided that the service has a sound knowledge of the particularities of addiction in the case of chemsex, and is itself linked with partner disciplines such as infectious diseases or psychiatry, to provide appropriate, multidisciplinary care for situations that are often complex and require multiple interventions from the outset.

[3] *AIDES. Chemsex. https://www.aides.org/chemsex.*

The benefits of cognitive behavioural therapies for chemsex users

Dorian Rollet / Addiction Specialist

With **Norman Therribout** / Psychologist - Sexologist
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The addiction team at Fernand-Widal Hospital has developed and tested a cognitive behavioural therapy (CBT) programme for chemsex users. This article presents initial insights and suggestions for improving care for these users.

Sexual and mental health professionals are confronted with difficulties treating and supporting chemsex users because of the lack of specific and standardised therapeutic tools. In their care pathways, users often face a double challenge: getting their addiction back under control, whether the aim is for complete withdrawal or for limited use, and having a fulfilling sex life in which they can control themselves and control their desire. The latter seems to be a necessary condition to lastingly stabilise the addiction disorder. Addressing both aspects can be challenging for care providers, as sexual health and addictions are generally treated by professionals with specific areas of expertise.

One of the other difficulties providing care for chemsex users is related to the particularity of their being members of the LGBT+ community, and the specificities of their using habits. In traditional group approaches used in addiction therapy, chemsex users can feel uncomfortable because of the substances they use, the sexual context in which they use, and the associated sexual practices (group sex, BDSM, fist-fucking, etc.). Also, the weight of stressful experiences related to their belonging to a minority means they need safe spaces in which to share.

To meet these needs, certain NGOs have created support groups specifically for gay and bisexual men practising chemsex. These groups are open: they do not require long-term commitment, and participants can join or leave the group at each session. They are particularly adapted to providing care for chemsex users because of their spontaneity in welcoming new members. They do not always have predefined therapeutic goals, and thus are more reactive to group dynamics. The NGOs AIDES and Arcat organise these groups within their respective programmes (cf. pp 66), as does the NGO Narcotics Anonymous with their LGBT+ groups.

The fact that new members can join at each session is the main drawback of these open groups. It limits the development of relationships between participants who are not new members, and discussions risk becoming repetitive from one session to the next.

Origin of the programme

Cognitive Behavioral Therapy (CBT) is a set of therapies that focus on acknowledging the connection between emotions, cognition and behaviour.

CBT is widely used in both addiction care[1] and in sexology[2], its framework providing the best common thread for therapeutic reflection and action. It is often used in group therapy approaches, particularly for addictions, whether they are focussing on preventing relapses, managing emotions or self-affirmation. CBT

[1] *Carroll KM, Kiluk BD. Cognitive behavioral interventions for alcohol and drug use disorders: Through the stage model and back again. Psychol Addict Behav J Soc Psychol Addict Behav. déc 2017;31(8):847-61.*

[2] *Mignot J, Blachère P, Gorin A, Tarquinio C. 36. Les thérapies cognitivo-comportementales en sexologie: leur place, leur action, leurs limites. In: Psychosexologie. 2018. p. 369-78. (Aide-Mémoire; vol. Dunod).*

helps patients develop strategies for managing risk situations and develop techniques that favour sobriety. The group approach facilitates vicarious learning – observing successes reported by peers – and cognitive restructuring, with participants sharing different points of view and experiencing reciprocal identification.

Although addiction healthcare for chemsexers has been developing, as yet there exists no validated therapy adapted to the French context. Several programs already exist abroad[3], including Reback and Shoptaw's American programme for methamphetamine-abusing gay and bisexual men[4] which served as a model for us here in France, but they have certain limits. The first is that they generally only address methamphetamine use and are not adapted for people who use cathinones, as do the majority of French chemsexers. They also focus on reducing "high-risk" sexual relations, which may no longer be the most appropriate aim for MSM, now that PrEP is becoming more common. This particular programme is also tinged with spiritual aspects inspired by the Minnesota model. Lastly, it was designed to last 24 sessions, with three sessions per week, a rhythm that seemed difficult to set up from a logistical point of view, and too heavy for the patients.

We therefore developed, then tested a closed-group CBT programme for chemsex users in Fernand-Widal Hospital's Addiction Medicine Service. Closed groups help participants feel safe, and allow them to progressively form bonds that are essential for group cohesion. This programme is the result of collaboration between the Monceau Addiction Care Centre and The Checkpoint-Paris Sexual Health Centre. We were mandated by these two organisations to design a group therapy protocol, one of our members having already set up a similar group for psychostimulant users[5]. Within this collaboration, a first twelve-session protocol was developed and tested at the Monceau Addiction Care Centre in Paris, before being reworked to result in the 8-session model that is currently proposed at the Fernand-Widal Hospital.

[3] *Milhet M. APACHES - Attentes et PArcours liés au CHEmSex. OFDT; 2019 mai p. 98.*

[4] *Reback CJ, Shoptaw S. Development of an evidence-based, gay-specific cognitive behavioral therapy intervention for methamphetamine-abusing gay and bisexual men. Addict Behav. août 2014;39(8):1286-91.*

[5] *Karsinti E, Vorspan F, Therribout N, Icick R, Bloch V, Fortias M, et al. A specific cognitive behavioral group therapy program for stimulant use disorder. Front Psychiatry. 2022;13:1031067.*

[6] *Kim MT, Heitkemper EM, Hébert ET, Hecht J, Crawford A, Nnaka T, et al. Redesigning culturally tailored intervention in the precision health era: Self-management science context. Nurs Outlook. 2022;70(5):710-24.*

[7] *Miller WR, Rollnick S. Motivational Interviewing: Helping People Change. Guilford Press; 2012. 497 p.*

Structure of the therapy

This protocol offers short-term therapy, in one 90-minute session per week, over a period of 8 consecutive weeks with 8 to 12 participants per cycle. The sessions are led by two to three professionals (psychologists and doctors) with expertise in addiction, psychology, psychiatry and sexology. Participants are referred by a series of addiction and sexual health centres in Paris, and must already be receiving individual care for chemsex. Before joining a group cycle, future participants are invited to an initial consultation where professionals gather information needed for each patient, and present the programme and group rules. During a final consultation, participants review their experience with regard to the programme and discuss how to optimise their future care pathways.

The sessions address different themes related to chemsex. Specific therapeutic materials have been created, inspired by existing tools and based on scientific data.

The first point is preventing relapses: the aim is to understand addiction mechanisms and the processes involved in behaviour change, to identify risk factors, and manage cravings and missteps. It is not just a question of discussing personal points of view and the difficulties encountered. The therapeutic approach highlights practical tools and strategies for participants. Also, we have chosen to name the drugs participants use, in order to include some pharmacology in the psychoeducation being provided.

The second point is sexology. Using tools such as Masters & Johnson's four phase model of sexual response to discuss the notion of arousal and the impact of substances, the therapy sessions are structured discussions that emphasise desired sexuality, including relational and emotional aspects. The aim is for a cognitive restructuring of the sexual patterns participants have become accustomed to. Sometimes chemsex users in recovery will avoid sex altogether, even when they are off drugs, a phenomenon which paradoxically sustains craving for substances. By helping patients' thought processes become more flexible, it is possible to work on the behavioural aspects that feed the vicious circle of sexual difficulty.

The last point: integrating community aspects. The therapy insists on the cultural norms and values of LGBT+ communities in order to better meet their specific needs and preferences and to improve engagement and results. This is manifested for instance by referring to venues used by the MSM to socialise or to have sex, and by using illustrations that are adapted to the target population and their vocabulary (ex: *bareback, cruising, circuit parties*, etc.). During group discussions, the therapists also highlight experiences gay and bisexual men have in common, or, with the aim of helping participants understand the effects on their mental health of belonging to a sexual minority, bring up the concept of minority stress. Culturally adapted interventions are more efficient than interventions that are not adapted to participants[6]. In group therapy, these adaptations help participants feel recognised and make discussions easier.

On a relational level, the therapists use motivational interviewing, a collaborative, person-centred communication approach that focuses on goals and insists on change talk[7]. Motivational interviewing goes beyond cultural adaptation, by acknowledging the intersection of various social identities

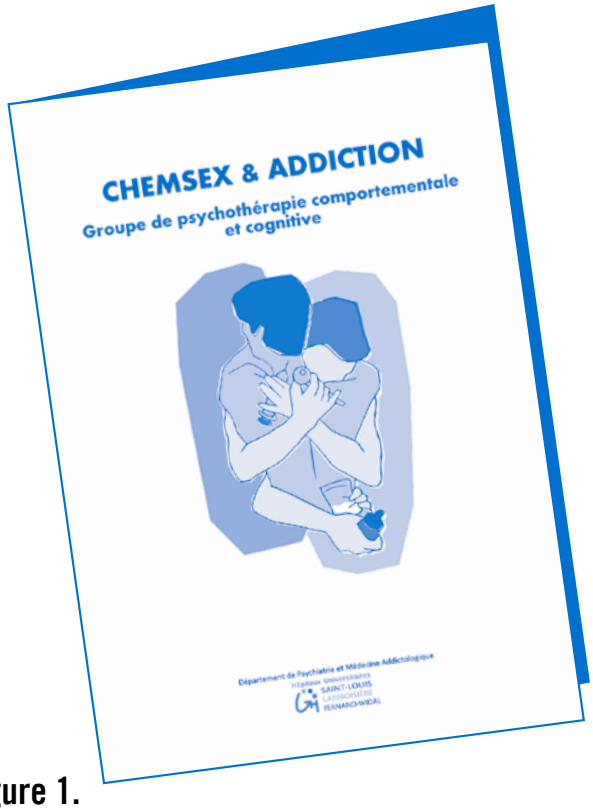


Figure 1.
Participants' therapy manual

and highlighting individual belief systems, characteristics and circumstances. It has been chosen to use first names for both participants and therapists, to favour spontaneity in the conversations. However the therapists still use the French *"vous"* pronoun (instead of the more familiar *"tu"*), to maintain a degree of distance that helps participants feel safe.

The therapy is based on a manual that is given to each participant. It follows the order of the sessions and includes spaces where participants can take notes (Figure 1). It can be consulted after sessions are over. In between sessions, participants are invited to do "homework": organising their daily life for sobriety, using Beck's column technique – a classic CBT tool, that highlights the connection between emotions and thoughts – or a chart to measure pros and cons with regard to sexological issues.

Evaluation of the therapy

A total of four therapy cycles have been completed, involving some 50 participants. As usual in the scientific approach to CBT, the intervention's efficacy is evaluated using psychometric scales at the start, mid-point and end of the programme (Figure 2).

The Drug Use Disorder Identification Test (DUDIT) is used to assess the intensity of addictive disorders, the *Craving Experience Questionnaire* to measure craving intensity and frequency, and the *Timeline Followback* to monitor use over the past month. The statistical analysis – the complete results of which are currently being published – focus on the participants' characteristics, participation rate and results on the psychometric scales. They highlight a statistically significant drop in DUDIT scores between T0 and T2 eight weeks later, as well as in intensity and frequency scores for the *Craving Experience Questionnaire*. The *Timeline Followback* results did not show a significant decrease in drug use. However, these latter results are distorted by memory bias that is inherent in this type of declared rating.

Setting up and leading the groups allowed clinicians to learn about users' lived experience. During sessions, an outside observer was present, noting down quotes during group discussions, to illustrate observations.

Relational and sexual aspects

During group discussions, chemsex network relations are a recurring theme. As described in the APACHES qualitative survey[3], while substances are used to meet and get to know people more easily, participants report individualism among peers and a tendency to be opportunistic in relationships, a tendency exaggerated by the substances' effects, and according to availability and sexual affinities. Chemsex can also serve to compensate for narcissistic weaknesses, where sexual encounters and being able to hook up serve as personal validation, at the cost of stereotypical seduction games. This can lead to participants lowering their standards when choosing partners, and result in dissonance and lowering self-esteem.

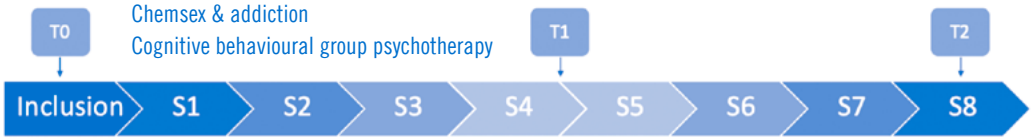
"You're alone with your drugs and ultimately have the illusion of being with the other person... »
"I'm the cake, the other person is the cherry."
"I have felt self-transcendence, but after months of using, I feel like I'm losing my dignity."

Another recurring theme is the search for affection: chemsex can serve as a mediator for meeting a possible lover and, for some participants, using chemsex gives a fleeting experience of romantic connection, by sharing feelings of intense connection, as observed in R. Amaro's qualitative study[8]. This strategy proves to be ineffective: having brief and superficial relations increases people's isolation. For many users, this leads to a feeling of loneliness. In turn, chemsex that was initially a sexual "enhancer" becomes necessary to keep having a sex life.

"Using was becoming an obsession, I only went towards people who were into chems, it isolated me."
"Since chemsex, I have had an intense, long, mechanical sex-life. I'd like to get back to simplicity, sensitivity and sensuality."

Besides difficulties in returning to sex without substances and the fear of having comparatively bland and unsatisfying sex, it should be noted that confusion often occurred in participants' discussions. Sexual arousal and the chemical

Figure 2. Organisation of the psychometric evaluation for participants



pleasure due to the substances often appeared to be inseparable and consubstantial.

Specific triggers

CBT tools to prevent relapse include ways to manage exposure to craving triggers. In substance-use disorders related to chemsex, daily sexual desire and exposure to situations with flirting are specific triggers. So, for many patients, staying sober has meant no more dating apps and sexual abstinence. In chemsex, using can be intermittent and recurring and craving happens particularly at weekends, when encounters and other social activities are more frequent. Craving is also triggered by alcohol, because of the disinhibition it causes, and can lead to slips. This is quite similar to the experience of cocaine users: over half of their relapses happen under the influence of alcohol[9]. In response to this, chemsexers schedule their weekends, so as not to let the product in.

"Sharing allows us to get tips to manage how we use."
"What's really helpful is to get into daily action."
"Now, when I'm tempted, I can ask myself alternative questions that help me say to myself: no, you have better things to do..."

For certain slam users, simply seeing their veins or other people's can be a specific and recurrent trigger. It can lead to an obsession for finding a "usable" vein, even independently of any plan to use. Some users see sexual symbolism in the needle and a shift in their fantasies with injection being eroticized. This specificity can lead to a split within groups, between injectors who identify with each other, and other participants.

"When I see my veins, or other people's, it can trigger craving."
"I see something symbolic in the needle, the act of piercing the skin."
"When I look at my vein, I think about the needle, the blood and the pleasure building up inside me."

Limitations and future directions

The closed-group format has advantages but also certain limitations. First, the intervention's fixed length: it was designed to last eight weeks, taking into account the fact that no shows are to be expected in treatment groups for addiction. This length seemed relatively short compared to the length of individual treatment that is often necessary to control addiction disorders. Also, there is no further evaluation of the group's effect, after the review that is done in the 8th week. There is no certainty that the therapeutic effect does not wear off in the weeks following the intervention.

A theme that was not initially taken into account was psychotrauma: certain participants share traumatic experiences related to chemsex, with non-consensual sex due to altered states of consciousness under the effect of drugs. Sometimes these experiences echo trauma that has taken place earlier in their lives. The team has had to include these themes in discussions unexpectedly, but traumatic memory requires specific care for these patients with addictive disorder.

"I have flashbacks of people I may have endangered. When this happens I feel shame, disgust, anxiety. [...] Looking back on it, I'm happy I stopped. I feel like it was a different person."

The first results indicate the protocol's good acceptability and feasibility. As well as a control group, future studies should include multicentric coordination with larger samples. Several similar groups have been created around Paris, at the Monceau Addiction Care Centre, the LGBT mental health centre CeSaMe and the Tolbiac Day Clinic. Coordination within a network of professionals is essential for these programs to be implemented and perpetuated.

The authors thank the professionals and healthcare centres for their trust and referrals: Spot Beaumarchais, the 190, Checkpoint-Paris, SMIT Saint-Louis, and Espace Murger, Marmottan, La Terrasse, and Ménilmontant.

[8] *Amaro R. Taking Chances for Love? Reflections on Love, Risk, and Harm Reduction in a Gay Slamming Subculture. Contemp Drug Probl. 1 sept 2016;43(3):216-27.*

[9] *McKay JR, Alterman AI, Rutherford MJ, Cacciola JS, McLellan AT. The relationship of alcohol use to cocaine relapse in cocaine dependent patients in an aftercare study. J Stud Alcohol. mars 1999;60(2):176-80.*

Pioneering Amsterdam

Christelle Destombes

In the center of Amsterdam, in a building that used to be a school, then a squat and is now occupied by solidarity organisations, Mainline has offices with high ceilings, tall glass cabinets and a profusion of semi-tropical plants. All imaginable harm reduction materials are available there. Leon Knoops, who has been working at Mainline since 2006, describes the tools he has helped develop in their work on chemsex.

Mainline was created in 1990 and focuses on harm reduction. It addressed drug use at a time when injectors had no idea about the risks of intravenous HIV transmission. Information, harm reduction and fighting discrimination are the main activities of this organisation that encountered MSM drug use at the beginning of the 2000s. Leon Knoops remembers: "As a gay man and Aids survivor, I worked for years in gay clubs and bars. I saw that a lot of gay men already had issues with drugs and alcohol and that there was more going on than we knew about". In 2008, he took part in a first research project: *"MSM, drugs and sexual risks."* "I did 25 in-depth interviews with homosexual men in Amsterdam aged 21 to 67. One out of five told me they no longer used drugs in bars or clubs, but during sex. That was the first time I heard about chemsex."

This research, unprecedented in the Netherlands, shows MSM use drugs twice as much as heterosexual men. Men over 45 or who are HIV positive use three times as much. "We also discovered the gay community is trendsetting in terms of new drugs, particularly GHB." In 2012, crystal meth appeared, imported by men (as legend would have it, KLM air stewards) who had travelled to Australia, the United States or Vietnam. "We had started training professionals in polyclinics, particularly those who take care of HIV and STIs. That's when we heard about the increasing use of crystal meth. But at the time, one gram cost 250 euros, which meant only rich people could afford it", notes Knoops.

Developing responses

Koops had an idea for a new study and carried out 27 interviews with users and ex-users[1]. "That was when I first heard about crystal meth injection and I think ours was the second international report to mention it." This study was published in 2015 and supported by Soa Aids Netherlands (cf. p. sq.). It was presented during a meeting with approximately 150 professionals… "The conclusion was that there wasn't enough information, neither for the target group nor for professionals. There was no expertise and, to begin with, no cooperation."

So Mainline became an expert: "We published several magazines with information about the substances, harm reduction, etc. And we published a booklet about safer injections as HCV rose around 2015-2016."[2] In 2016, Mainline organised meetings for MSM and bisexual chemsexers, as well as meetings for ex-users. "We still have the group for ex-users, says Leon. On Wednesdays, at 7:30 p.m., we come together here, in the 'library'. One week the meeting is in English, and the next in Dutch." The organisation created a website to inform and support users and social workers (https://chemsex.nl/en/). The site aims to help users access nearby resources[3], it monitors dating apps, provides training for health professionals nationwide to care for chemsexers, and is at the root of a network that comes together twice a year, the Amsterdam Chemsex Consultation. "This network was born after the first Chemsex forum in London, in 2016, with David Stuart" (cf. pp 55). There were four members at the beginning. Now it connects 22 organisations in Amsterdam. They can share information about new trends and above all cooperate[4], and identify professionals from specific fields, "for example, a trauma therapist who knows about chemsex, someone from the police, people who work in hospitals, in municipal health services (GGD), who know what chemsex is and won't be judgemental" insists Leon.

[1] *Tina and slamming: MSM, crystal meth and intravenous drug use in a sexual setting, https://bdoc.ofdt.fr/index.php?lvl=notice_display&id=79223*

[2] *https://mainline.nl/en/shop/*

[3] *https://chemsex.nl/en/care-finder/*

[4] *Inside the network: Amsterdam Center for Sex Workers, Amsterdam UMC, Arkin/Jellinek, ARQ Centrum 45, Center for Sexual Health GGD Amsterdam, Choices, Club ChUrch, DC Klinieken Lairesse, Kaleidos, HVO-Quirido, Hiv Vereniging, Huisartsenpraktijk, Heijnen, NZ Sauna, Mainline, Menaswell, Sexual Health Practice Amsterdam, Queer & Sober, Pink in Blue, Sexology Expertise Center Haarlem, Soa Aids Nederland.*

[5] *His phone number is available on Mainline's chemsexer support website: https://mainline.nl/en/chemsex-support/*

Leaflets by Mainline available on their website to order

Leon Knoops, © Mainline

Paul Zantkuijl, a strategy advisor at Soa Aids, notes that one issue with regard to handling chemsex is related to the way the health system is organised: "If you go to the Jellinek addiction centre in Amsterdam, there is no sexologist. You have to send the patient somewhere else. It's problematic. The response is fragmented, insufficient and there are waiting lists – particularly for PrEp. That's why it is important for actors to communicate within the networks. Sometimes it just depends on one person."

Covid, a particle accelerator

In Amsterdam, like in Brussels and Paris, Covid amplified everything. "If you take the classical group of injecting drug users, it's some 1 000 people in the whole of Netherlands today, compared to 80 000 in the 1980s. But take MSM who are slamming, and there are far more than that. It has become very normal, particularly since Covid, explains Leon. Most people who are looking for help today lost control back then…" From crystal, users moved on to other substances: "every possible powder: speed, cocaine, MDMA, NPS, 3-MMC which is very popular right now, even though it is illegal".

Partly because the effects of 3-MMC are shorter, the drug is both popular but also more dangerous, as users do rounds of injections. "I see today the same problems as when I worked in injection rooms. People have no veins left." A WhatsApp group was created so people can get in touch with him[5] or other peer counsellors in the organisation and develop a sort of self-help.

"It is a hard job, admits Knoops. It is getting more and more difficult. I'm worried about how normalised drug injection is becoming, and how difficult it is for users to get back to sex without substances. It's a very heavy kind of addiction, because it's not only about drugs, it's also about sex. It's challenging to construct a sex life without drugs when you have been choosing chemsex for a long time." Mainline's latest booklet is called "Dropping chemsex".

The police in Amsterdam

The Dutch police force has a service dedicated to LGBT questions. This is helpful when they're called by health services and asked to intervene at a chemsex party. Certain scenes they have witnessed led the police to contact Mainline in 2016 to get training in managing chemsexers, and also victims of theft, rape and abuse… "It's good they belong to the network", says Leon Knoops. "The police have a completely different point of view on drug use and chemsex…" In the Netherlands, possession of up to one gram of drugs for personal use is authorised.

Services available in Amsterdam

GGD

The Dutch public health services (GGD) provide universal but sometimes specialised access… Amsterdam's GGD centre for instance offers one hour of support and counselling to chemsexers on Tuesday and Thursday evenings from 6 to 9 p.m. People can drop in and talk to peer counsellors or send a question by email to chemsex@ggd.amsterdam.nl.

Crystal meth Anonymous

Crystal meth Anonymous was created in 2018. The group meets on Saturdays, and brings together ex-users, following NA's 12-step model. https://www.crystalmeth.org/meetings/?meeting=cma-amsterdam

Research and training supported by Soa Aids

In the Netherlands, healthcare prevention, promotion and protection depend on city councils. With 26 sexual health centres around the country, attention to chemsex can vary from one region to another, according to Ronald Berends, who works for Soa Aids. This organisation, funded by the national institute for public health and the environment (RIVM), advises sexual health centres that want to address the question of chemsex.

Soa Aids developed a research agenda to assess what is already in place and identify what is missing, in order to improve the treatment offer and develop prevention, harm reduction and treatment interventions. An initial step will involve conducting further research on chemsex use among MSM, to work with more up-to-date national data. In 2018, according to Soa Aids' strategic advisor, Paul Zantkuijl, a first study showed "that a third of the people who had answered the questions about drugs used them in chemsex contexts".

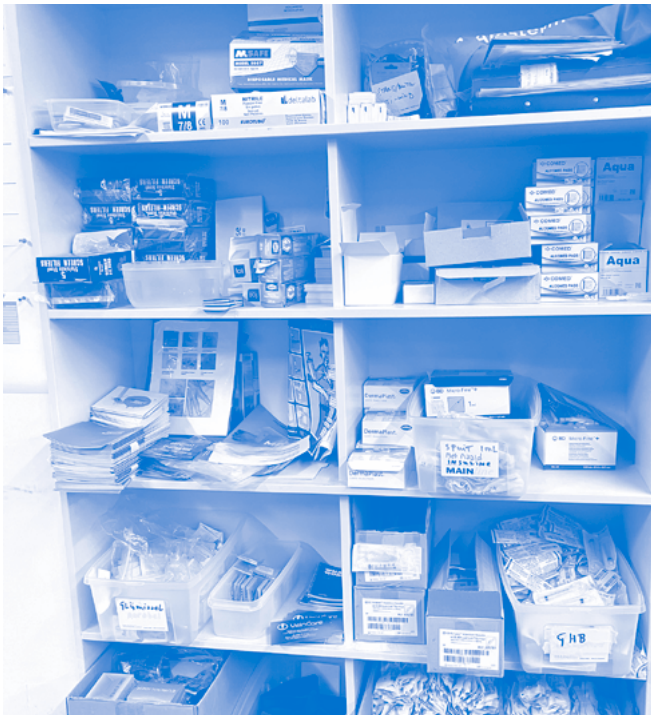
With the national chemsex network of sexual health centre professionals (Zuid-Holland Regional Chemsex Consultation), Soa Aids has developed an e-learning module for healthcare professionals. In two hours, it defines chemsex, its reasons, the role of healthcare professionals, how to discuss the subject, the substances that are being used, and also issues of consent, harm reduction, how to identify problematic use and help the person take back control. (https://leren.soaaids.nl/local/coursedetails/view.php?id=411)

The organisation is also present on the gay scene: two debates about chemsex were organised in clubs, the first in 2018 with over a hundred participants and another in 2023. Chemsex takes place in private settings and gay social life evolves with the major clubs that "belonged" to the community disappearing. However this kind of action is a way of making contact with young gay men, some of them migrants, as they arrive in Amsterdam. In the hope of also making contact with chemsexers' loved ones, families and friends, Soa Aids will soon be holding meetings in Maastricht and Rotterdam.

After a last study in 2021 about how slam has been progressing in the Netherlands[6], Leon considers all the necessary theoretical work has been done – even if he would like to further investigate questions of sexual violence and consent, which he sees as being the last taboo. "When you're gay and you enter into this culture, there are norms and values. Peer pressure is strong, you have to belong to a group… But getting raped because you're under the influence of drugs can't be part of the gay community's values."

Mainline

Frederik Hendrikstraat 111-115
1052 HN, Amsterdam
Chemsex groups on Wednesday evenings, alternating English and Dutch.
l.knoops@mainline.nl



Harm reduction material at Mainline, © CD

On-site harm reduction

Mainline is a low-threshold organisation. It manages a needle exchange programme from 3 to 6 p.m. two days a week, where users can collect equipment and all available information. Substances are occasionally tested on site. According to Leon Knoops, after 3-MMC was prohibited in September 2021, its quality deteriorated: 90% of the 3-MMC samples that are tested contain not just 3-MMC, but a combination of 3 and 2-MMC and other NPS.

[6] *Slamming in the Netherlands, in Dutch: https://mainline.nl/wp-content/uploads/2023/11/Slammen_NL_factsheet_2021.pdf*

AMSTERDAM

Jason Farrell, Choices

Interview by Christelle Destombes

Jason Farrell created the first needle exchange programme in New York where he saw the first gay men injecting methamphetamine... A pioneer in community-based harm reduction and EMCDDA correspondent, he has been living in the Netherlands for some fifteen years where he has designed services to meet the needs of drug users, gays, migrants and chemsexers.

Jason Farrell, © Choices

Choices App.

"I prepare people for care interventions. Here, to get help from drug services or mental health services, there's a waiting list. If you call to make an appointment for substance use care, you can get an intake appointment rapidly, but then it can take from three to six weeks to actually get admitted. What happens during this time? We provide treatment readiness interventions for people waiting to get into treatment. We prepare them so as to improve retention in care and the outcome.

I had a psychologist working with me for one day a week, and on Monday evenings we had a group for men doing chemsex. It was doing well, word of mouth got around the community. And then Covid happened…

During that period, we were contacted by public authorities to provide care for migrants, particularly gay migrants, who were persecuted in their countries and in lockdown here with their compatriots… We opened a helpline in several languages, operated by twelve volunteers, from Monday to Saturday. People can call to get support. We have also made a booklet about sexual consent: "Rules for backrooms and saunas". These are unwritten rules to explain how these places work, to young migrants who arrive and get exploited, drawn into chemsex thinking it's the norm…

Now we're launching a new chemsex project based on the success of this helpline and our treatment readiness interventions. We want to see if a helpline for chemsexers could be useful, particularly for those who live outside big cities. We're targeting them because prevalence is just as high outside cities but there aren't enough places where you can get help! We'd like to see if this could fill a gap, so people could talk to someone and access treatment. I have a research project that involves interviewing twenty or so chemsexers to help me develop this tool. We are seeing more and more young people touched by this phenomenon; for example, I was contacted by students at Limburg University who want to raise awareness and inform high schoolers.

Also, our Choices app that is available for cell-phones helps users find services close to them, whether to get help with drug and alcohol problems, sexual health or find self-help groups. I call this community care; it is accessible after normal working hours. You can call when everywhere else is shut.

There have to be safe spaces for gay people to talk. We live in a city where controlled drug use is socially acceptable. But when you can no longer manage your drug use, you're stigmatised by the community. That's when people come to us: they want to feel socially accepted, they feel like they've lost control and seek guidance to taking the first steps towards establishing a pragmatic prevention plan. Where's the peer support? I don't think you have to do chemsex to belong to the gay community, and we have to get that message across to young people."

https://choicescenter.nl/en/

Data
for the Netherlands

RIVM, the Dutch National Institute for Public Health and the Environment, measures the incidence of STIs in Sexual Health Centres (CSG).
In 2022, concerning consultations for people using PrEP:

MSM

In 39% of all PrEP consultations, MSM declared having taken part in chemsex in the last 6 months.

Transgender and gender-diverse individuals

In 31% of all Sexual Health Centre consultations, patients declared having taken part in chemsex in the last 6 months:

– in 25% of consultations with trans men
– in 33% of consultations with trans women
– in 31% of consultations with other gender-diverse people.

Slamming (injecting drugs) among MSM

In 2022, slamming in the past 6 months was recorded in 1.4% of MSM-PrEP consultations (427 consultations with 250 MSM) and in 0.8% of sexual healthcare consultations (347 consultations with 274 people). However it is to be noted that questions about slamming are not mandatory during consultations. Only half of the people who came to the centres for PrEP, or others having declared alcohol and/or drug use related to sex, answered this question.

Dutch studies among MSM who have chemsex show that 64% to 86% of these MSM have had anal sex without condoms in the last 6 months.

PrEp Access

A pilot program has subsidised PrEP from 2019 to 2024. However, it is limited to 8 500 participants, which is insufficient with regard to the populations concerned. Within this model, PrEP and related services are available only in sexual health clinics. The co-payment for PrEP in this programme is 7,50€ for 30 tablets. Access varies between provinces. Once the pilot project has come to an end, only a relatively small number of people will be able to get access, mainly in sexual health clinics.

Barcelona: a gay community serving the community

Tim Madesclaire for *Swaps*

With a growing presence in Barcelona, the AIDS NGO Stop has adapted its services to chemsex, building on a community outreach scheme called ChemSex Support. Gerard Funes and Georges Azzi, two activists working in this field, explain how it came about and what Stop has to offer.

The Catalan capital is a popular destination for gays from all over the world, particularly in the summer when major festive events take place. Already in the early 2010s, practices were identified that could be construed as chemsex. According to Gerard Funes, one of the members of Stop's Chemsex committee, the two main vectors for its spread have been tourism and mobile sex workers, who imported practices that they have then shared locally. "These two phenomena feed off each other", explains Gerard, who is himself a sex worker, and joined the association in 2019 after having been a beneficiary of its services. So, little by little, the usual practices of chemsex have been mixed with the consumption of products that, until now, were essentially festive.

One word, many realities

Around 2015, methamphetamine, cathinones and GBL were spotted. Their users began to experience problems and turned to community organisations for help. Stop then set up a psychological support service for chemsex users, initially without public aid. In 2019, chemsex was recognised as a public health issue by the local authorities. As for the term itself, it is difficult to pinpoint when it first appeared in Barcelona, even though Stop's support service is called… ChemSex Support. It is by no way certain that "chemsexers" have appropriated the term for themselves. Georges Azzi, who has been a member of Stop's Chemsex committee for two years, confirms: "On the apps, users use the term chems – 'do you take chems?' The term chemsex is mainly used by professionals, it's not a common word."

Journalists have helped to identify chemsex by using the term in a stigmatising and inaccurate way. "The media use a construct that doesn't correspond to reality", explains Gerard with a touch of irony. "They talk about 'taking part in chemsex', for example, as if that were a type of evening, confusing it with orgies[1]! For us, it's a phenomenon, for them it's the place where it happens. When a journalist mentions 'doing chemsex', it's clear that they don't really know what they're talking about."
Georges also insists on another aspect, to better define what chemsex covers: "It's not just the use of drugs to enhance and intensify pleasure in a sexual context in order to prolong it. We recently made it clear that chemsex must be consensual. Putting GBL in someone's drink without their consent is no longer chemsex." Gerard adds: "We debated this because the media started using the word chemsex as a synonym for drug rape, even among straight people. We added consent to the definition of chemsex to distinguish it from all that. If there is violence, if there is aggression, then there is no chemsex." For the two activists, it's vital to remember the difference between chemical submission and chemsex. In doing so, they are aligning themselves with the new Spanish law known as *"Solo si es si"* (only "yes" means "yes"), which strictly redefines the notion of consent.

Products in constant evolution

In Barcelona, the products being used sometimes evolve as a result of the mobilisation and implementation of the response to the problems. Thus methamphetamine became popular around 2017-18, and its use exploded during the

[1] *In Barcelona they call it an orgy, whereas in France, they call it a "touze": both are home events that bring together several participants for sexual activity.*

The members of Stops's team: on the left Gerard Funes, in the center Georges Azzi, © Stop

lockdowns. Gerard says: "When Covid arrived, we had a big problem with chemsex, which peaked in 2020. Every city in Spain had its own product: in Valencia, it was alpha [alpha-PHP, a short-acting cathinone that produces strong *cravings*]; in Madrid and Seville, it was mephedrone. In Barcelona, methamphetamine." Following the health crisis, the meth situation seems to be improving. "We have seen some users switch to other products, particularly cathinones. One of the theories we have is that, given the excessive damage and consequences of crystal, users have given it up for other products."

However, this (relative) switch to cathinones has not meant the end of the problems, but rather an evolution towards other, less well-identified problems. The first of these concerned the different varieties of cathinones becoming available. In addition to 4-MMC, the original mephedrone, there have been, as elsewhere in Europe, 4-CMC, 3-MMC, alpha, MDPV (called *Monkey dust* here, as in Berlin), and so on. "People buy different products that they always call mephedrone", says Gerard. "A bit like in France, where all cathinones are referred to as '3'. What we're seeing is that some cathinones can be injected, while others cannot. There's a difference between alpha and 3-MMC: the former is much more harmful to the veins." This also has more general consequences for health, for example when a user is afraid to go to the doctor or take a sample because his veins are too damaged and he is afraid of being judged.

This diversification has also meant that product analysis has become more complex, even though it is not yet very well-developed in Barcelona. "The system has become less accessible, because there are long delays between the submission of the product and the results, and because you have to hand over the drugs…" laments Georges, who also mentions a problem with remote collection that had been stopped by the authorities. However, after discussions with the authorities, drug collection was resumed[2].

A community in touch with the field

Despite these obstacles, the care for chemsex is showing signs of improvement, "unless we don't manage to reach the people in difficulty", says Gerard tempering his optimism. This is the result of prevention and information campaigns run by community organisations and public authorities, but it is also the result of intensive community work, based on the involvement of the chemsexers themselves.

At Stop, the ChemSex Support programme is run by "current and former drug users. We're in touch with what's going on in the field, and we feel the *zeitgeist*", says Gerard. "All the members of the Chemsex committee are part of the community. We're the first to be aware of the emergence of a new drug or a new trend. For example, with the help of the Sex workers committee, we spotted a new misuse of eye drops as a substitute for crystal. Injected! We passed the information on to Energy Control, the organisation that carries out product analyses, with a view to research and improving our knowledge."[3]

Most ChemSex Support activities are run by volunteers, recruited each year from among current or former chemsexers. They undergo rigorous training over a two-month period, four hours a week. They also have to take part in a training weekend and, at the end of the cycle, pass a sort of exam. "Initially, the ChemSex Support volunteers were already part of Stop. But we opened up recruitment to chemsexers who had followed our programme", explains Gerard, who points out that not all candidates succeed in obtaining accreditation. But the principle is there: find the resources within the very community for which the services are intended, work with them to develop an offer that meets their needs as closely as possible, and enrich the projects with the experience of others.

In town and online

ChemSex Support's services are being developed online *via* the Chemsex Info website (https://chemsex.info/), which offers risk reduction resources, a kind of product dictionary, as well as a discussion forum and a blog, for ongoing information and exchange, as part of a self-support approach. Since 2015, the content has been expanded, with many archives still accessible. It is also possible to ask questions online, which are answered by a team of volunteers.

[2] *Product analysis is carried out by a national association called Energy Control: https://energycontrol-international.org*

[3] *For a summary of the research carried out by Stop, see: https://chemsex.info/wp-content/uploads/2018/02/chemsex-dossier.pdf*

Public authorities mobilised

"The Generalitat[1] of Barcelona funds our activities, followed by the Ministry of Health and then a small amount from the municipality", explains Georges. "In Spain, the health system is very decentralised, by region. Catalonia is one of the most progressive in this respect, and that's a good thing. However, to get things up and running, we had to exert pressure. Very often, requests were passed from one service to another, from HIV services to addiction services. In the end, things started to fall into place in 2019."

The authorities' efforts were focused on training healthcare staff. "The approach was mainly focused on abstinence, which was not well received in the LGBT community." In Barcelona, as elsewhere, people who practise chemsex often do not want to stop, they want to better manage their consumption. "This explains why they haven't found their place in public services, which are too focused on abstinence", explains Gerard.

The Catalan authorities have also funded research and information. "That wasn't the case everywhere", says Georges. "In Valencia, the regional government financed a prevention brochure which had to be withdrawn under pressure from the far right."

[1] *The Generalitat are the autonomous governments of certain regions of Spain.*

Epidemiology

According to a study published in 2022, out of 190 PrEP users followed at Hospital Clinic of Barcelona until October 2020, 89% reported drug use, and 63% disclosed that they had engaged in chemsex practices, initiated in 64% of cases within the past year.
https://pubmed.ncbi.nlm.nih.gov/35732910/

In the latest European MSM internet survey (EMIS 2017), the results for Spain showed that 14.1% of respondents had used drugs for sexual purposes in the last 12 months, with 0.8% reporting injecting drugs. These rates were higher for men living with HIV, men born outside Spain and residents of big cities.

In the city, the ChemSex Support activities and services are provided at the Stop premises, located in an area frequented by the LGBT community. The programme is based on Stop's existing services, adapted for chemsexers. As well as screening, treatment and follow-up services, there is also a back-to-work support service, modelled on what was provided by the trans Sex workers commission a few years ago. Chemsexers who are in a very precarious situation and have no accommodation (there are many of them in Barcelona) can also benefit from a domiciliation service that enables them to obtain assistance. Resources built up by other parts of the LGBT communities can thus be transposed to new issues.

The ChemSex Support programme was developed from the ground up: "All the projects we have developed are based on needs we have identified", explains Georges. "A recurring theme has been 'I don't know what to do this weekend, I'm just going to get high'. So we came up with solutions to help users meet up and connect in a different way. Chemsex can be a major factor in isolation."

For example, workshops and outings are offered at weekends as an alternative to chemsex: "There's hiking, jogging, even Zumba! We also organise workshops around sexuality to help participants redefine sex outside of chems. We offer BDSM workshops. We know that when people stop or reduce their use of drugs, there is often less pleasure, because there is less intensity in sexual relations. It's all about rediscovering practices that can be just as satisfying." Other harm reduction workshops, and occasional self-support or therapy groups, take place twice a month with around ten participants. "Everyone chooses what they want to do", says Gerard.

Successes and limitations

Around 150 chemsexers take part in the ChemSex Support programme every year. But this number is declining: "We don't know why", says Gerard. "We've started so many things, the activities, the groups, the welcoming… maybe it all ends up having an impact! Our hypothesis is that users are becoming stronger in their harm reduction practices. They cope better and are less likely to find themselves in a situation where they need someone to talk to face to face. The other, less optimistic hypothesis is that we are not reaching enough people."

For the two activists, the results and the satisfaction are there for all to see. They note that there is greater awareness on the part of community organisations and public services alike, and there is more information available. However, Georges remains cautious: "We have no control over what will happen in the community and how people consume. Every week, we see a new drug mentioned in the chat rooms we run. But the health system is now better prepared. We know how to deal with the situation. I've often taken people to the Hospital del Mar, the main hospital here, and I've seen how they deal with problems. For me, the experience of what has been done over the last four years has made a difference." For Gerard, the ChemSex Support programme has enabled chemsexers who were in very distressing situations, very isolated and desperate, to find a way out and a sense of meaning, by getting involved: "They took up what we were proposing, they were trained, they got involved in the community. They went to the authorities, they spoke up for themselves. They became politicised and defended their positions. They took an interest in medical issues and that benefited them and the community. These are things we can be proud of."

In Berlin, the importance of intervening as early as possible

Christelle Destombes

At Checkpoint in Berlin, chemsex is not taboo. To encourage clients to discuss the subject with counsellors, social workers or peers, Christopher Clay, who is in charge of public relations and is also a designer, has put his talents to good use.

A pocket-sized leaflet – "Sex and substance use, is everything going OK?" – is available in the waiting room. The idea of this informative leaflet is to let chemsexers know that here, they can talk about it without fear of being judged. "Checkpoint is first and foremost a specialist HIV and STI clinic, set up during the Covid pandemic when it was difficult to reach people who might have been involved in risky activities", he explains. "I thought that, sooner or later, everyone would need Checkpoint to access STI screening."

Thoughtful graphic communication

Checkpoint Berlin, which opened in 2019, is the result of cooperation between Berliner Aids-Hilfe, the German Infectious Diseases Physicians Group (Dagna) and the Berlin Gay Council *(Schwulenberatung Berlin)*. Like other sexual health centres dedicated to LGBTQIA+ people in Europe, Checkpoint's clientele includes chems users. Christopher Clay, for his part, speaks readily of his "experiences" and "a passion for the subject of chemsex". In addition to Checkpoint, he also works for another project of the Berlin Gay Council, *Sidekicks*, which is entirely dedicated to drug prevention. "Within these two organisations, I campaign for more to be done on chemsex, by identifying new projects and bringing them to fruition". The result is *Chemsex Check*, a sort of "chemsex bingo" that helps users weigh up the pros and cons and define their own limits, with a list of suggestions on "the positive and negative effects of chemsex". Among other comments, one finds: "my self-esteem is improving", "my sexual life is fulfilling", but also "I see my friends less", "I don't have sober sex anymore", "I consume alone", "I share my syringes", and so on. As the designer explains: "The list begins with positive things that reflect user experience; we don't know where they stand at this stage and we want them to understand that we're not just talking about problems and risks. We're trying to represent the whole experience".

This motivational approach is intended as a decision-making aid, without scores or bonus points. The chemsexers can circle the proposals they identify with and draw a line between the things with which they can identify and those they refuse. In the end, they can add up the pros and cons, set themselves goals and are encouraged to open the Checkpoint door to come and discuss their substance use, via "Just Talk" appointments in person or by video. After being tested with around twenty users and sent to David Stuart himself for his opinion, the *Chemsex Check* tool is now being adapted in France at the AIDES Checkpoint. It has already been adopted in Hamburg and has been translated into Swedish.

Specific consultations

"Just Talk" was not designed to deal solely with chemsex. However the issue is covered extensively, and Checkpoint is thinking about creating a specific support offer, with a more structured intervention. "We will soon be offering five consecutive appointments with our advisers", explains Christopher. "The *Chemsex Check* will be completed during the first module and will serve as an initial assessment. This intervention will be similar to what David Stuart was doing in London: identify a goal – reduce, use better, stop, etc. – and organise follow-up to help achieve the goal". This new system should be available by the end of the year.

Christopher Clay, © Checkpoint Berlin

Berlin, with its huge clubs and avant-garde queer scene, is one of the hubs of the gay party scene. Yet its response to chemsex does not seem to be up to the task. The Berlin Gay Council does offer weekly discussion groups, run by psychologists, without registration, alternating between English and German. The Council also offers more structured support "in terms of drug addiction, rehabilitation, referral to therapies and all these wonderful services", says Christopher, "but it's simply overwhelmed, with waiting lists of almost nine months to get an appointment. We have to fill the gaps, there are loads of people waiting for help".

New drugs

Here too, it is difficult to estimate the precise scale of the phenomenon, and we are eagerly awaiting the results of the EMIS 2024 study. One thing is clear: Berlin is now in the grip of new drugs. Like *"monkey dust"*, a smokable substance that is increasingly used, more potent and riskier than mephedrone and 3-MMC. "It's still a niche product", says Christopher, "but it's become very visible in the community. And that makes us fear that, like G or mephedrone before, it will spread to the party scene in general, and not just to private parties".

For Sidekicks, the harm reduction aspect of his work, Christopher goes to gay clubs, where information, advice and harm reduction materials are distributed. "Half of our advice is on substance use and half on safer sex and sexuality. However, some clubs find it difficult to distribute equipment…" While mephedrone and 3-MMC are popular in the party scene, 'G', with its risk of overdose, is banned from clubs. "Clubs really hate G, it's the only substance they check when you enter the club, there are signs saying 'zero tolerance, you'll be banned immediately if you're in possession of G', which is problematic because it just makes consumption more underground", laments Christopher.

Sidekicks does, however, distribute a small information card – one side in English and the other in German – with advice on what to do in the event of an emergency such as an overdose. Another brochure, aimed at younger people, aims to reduce the risks associated with chemsex. Easy to slip into a pocket, it describes the phenomenon, the substances used, the risks involved, the precautions to be taken, the interactions with treatments and provides advice on harm reduction. The products are colour-coded to indicate the scale of risk – red for monkey dust – to provide practical information. "In this way, people can set their own limits and make the right decision, or make decisions that suit them in their particular context."

RoR in private places

This prevention work, which is also duplicated on social networks, sometimes comes up against algorithms governed by American rules, which make no distinction between harm reduction and the promotion of drug use. As the party moves into private places, Sidekicks is working on two harm reduction kits that users can order online, so as to reach all users. The idea is to provide a suitcase with tried and tested items for sex and drug harm reduction – one of the suitcases includes a syringe for injectors – as well as magnesium food supplements to limit jaw twitching.

Getting in touch with users in private places and raising the issue of consent are the two projects Christopher Clay intends developing now. "I want people at private parties to also benefit from harm reduction thanks to this pack. This would facilitate access to the support system. It's very important to act early and support people at the earliest stages of their user journey, not just when they desperately need help."

Checkpoint Berlin

checkpoint-bln.de
25 people
Hermannstr. 256-258,
Open Monday to Friday from 2 pm to 8 pm

sidekicks.berlin

8 people dedicated to harm reduction in clubs
P.O. Box 12 05 05, 10595 Berlin
As well as providing information, the site includes a map of chemsex support venues in Berlin.
https://sidekicks.berlin/en/help-drugs-chemsex/

BISS, a new initiative for "sexualised substance use"

Christelle Destombes

In Germany, a very recent federal initiative, BISS, is bringing together practitioners and academics, doctors, community organisations and peers to build the next stage in the response to chemsex. Review with Dr Martin Viehweger, who co-founded the initiative and sits on its board of directors.

Martin Viehweger is one of the co-founders of the BISS initiative (*Bundesinitiative für sexualisierten Substanzkonsum e.V.*[1]). A doctor specialising in infectious diseases, he heads Viropraxis[2], an organisation offering low-threshold services in both Berlin and Zurich. As a specialist, he designs, develops and runs community projects on sexual health and education, chemsex, and access to care for trans people, among other topics. He has also led a number of *Let's talk about Sex and Drugs*[3] sessions, which are open-mic meetings that allow chemsexers to discuss their practices in bars or community clubs. These sessions have been running for ten years in Berlin and more recently in Zurich.

A chemsex action network already existed in Berlin, bringing together different players, from addictologists to sex therapists, academics, peers, members of associations and social workers. Meeting once or twice a year, it allowed for more or less informal exchanges. However, "we needed an official structure", explains Martin Viehweger. "That's why we created BISS. The structure brings together representatives from the universities of Munich and Augsburg, psychiatrists, neurologists and toxicologists from Tübingen, members of the Cologne rehabilitation clinic, representatives of NGOs and users. It's a truly cross-sector approach."

Three pillars

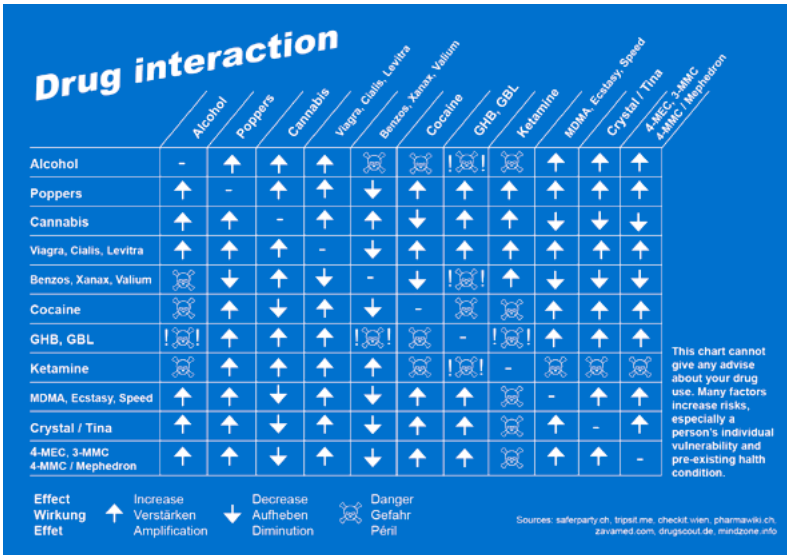
The BISS approach is based on three pillars: the first concerns raising awareness among users, who meet up at private parties and who therefore do not come into contact with the usual support programmes. How can we reach them and give them access to harm reduction advice? The second pillar concerns diagnosis and treatment, to identify the needs of users and adapt care. On this subject, a guide is being drawn up for doctors and social workers who meet chemsex users: "We need to adapt health professionals' practices. For example, psychotherapists want their patients to be abstinent. But if you only use meth once a month, the main issue is probably not abstinence. Shrinks

[1] https://biss-chemsex.com/ BISS is organising its first chemsex forum in Berlin in March 2025: the "Chemkon".

[2] https://www.viropraxis.de/

[3] https://www.instagram.com/letstalkaboutsexanddrugs/

[4] https://www.fixpunkt.org/ https://schwulenberatungberlin.de/ https://vistaberlin.de/



A drug chart used at Viropraxis

need to be able to discuss sexuality with their patients. What's more, sexual therapies should be covered by the health insurance system."

This is partly what BISS's third policy pillar is about: the initiative advocates the introduction of prevention programmes, including on the use of illicit products, and the reform of the care systems. The organisation has already begun training health professionals in how to deal with drug users: "We also need to train ourselves", says Martin. "We have to keep abreast of changes in consumption patterns and identify new developments. For example, there are a lot of new cathinones, and it's our duty to know how dangerous they are and how people use them." For Martin Viehweger, "BISS is the vessel that allows us to do all this", while maintaining a vital link with users.

Drug testing in Berlin

Over the past year, three NGOs – Fixpunkt, Schwulenberatung and Vista[4] – have set up a drug-testing programme for drug users. "These testing programmes open up a dialogue with users, explains Martin. In the local scene in Zurich, users don't think first of me being a doctor, so they talk to me more easily about their drug use."In Berlin, having your drugs tested is not yet common practice: "It's

Dr Martin Viehweger, © Anne Gabriel-Jürgens

new", says Martin. "I hope that my colleagues in Berlin will take up this practice. We're going to give chemsex training to the counsellors who do the drug-testing."

At the Viropraxis Clinic, Martin sees LGBTQIA+ patients with a holistic approach: "The one-to-one interviews I carry out focus primarily on questions of sexual health, STI screening, introduction to PrEP, etc. But in this private, one-to-one consultation, we very often talk about sexuality and problems linked to intimacy". If necessary, the doctor can refer patients to "We are Village"[5], an organisation founded by former chemsexers that proposes therapeutic work around body issues. "The association offers workshops, gatherings and weekends where you can meet new people while working on stimulating your body in a context of sobriety". An "essential" approach, according to the doctor.

[5] *https://wearevillage.org/*

Training peers in self-support *with Quapsss*

The AIDS charity Deutsche Aids Hilfe has developed a training tool on the subject of chemsex, by and for peers, based on a research project. It can also be used by social workers and therapists. The aim is to enhance the skills of chemsexers in the areas of sexuality, consumption/addiction, body perception, self-determination and social skills.

Quapsss stands for "developing quality in mutual support for MSM who use psychoactive substances in a sexual context". This innovative concept began as a research project from 2019 to 2023, supported by the Ministry of Health and several partner organisations. According to Urs Gamsavar, sex therapist & chemsex social worker for Deutsche Aids Hilfe, "Quapsss is defined as a semi-guided, innovative and dynamic group for MSM who practise chemsex and who want to improve their living conditions. The concept is based on a self-help approach and offers specific skill-building modules, which are selected by the group facilitator according to the needs of the participants".

The process begins with training the future group "leaders" in the skills needed to run the groups: framing, crisis management and so on. Once trained, these peers, former chemsexers or health professionals (sex therapists, etc.) provide support to various groups for at least a year. There are several such groups in Berlin, for example, with the Mann-o-Meter organisation[1], and others in Cologne, Hamburg and Munich. Within each group, participants define their objectives individually: what goals do they set themselves, what changes do they want to bring about, in terms of drugs or sexuality? For example, some people may be aiming for abstinence, others to be able to resume their sexuality without drugs; some simply want to use less or differently. While this approach may be reminiscent of the 12-step groups on which it is based, it does not impose abstinence on all participants and seeks to free itself from the guilt or spirituality often found there.

Dr. Dirk Sander and Urs Gamsavar led the initial research project and have been closely following the development of these groups ever since. Urs sits on the two-headed board of BISS, the new federal initiative on chemsex. He believes that it is essential to translate theory into practice, and to enable this method to be developed, a 112-page open-source manual on Quapsss training has been produced[2]. Available only in German for the time being, Urs would like to see it translated into English: "Berlin is a very international city and we lack peers who speak English and Spanish to create more self-support groups."

[1] *https://www.mann-o-meter.de/english*

[2] *https://www.aidshilfe.de/shop/archiv/handbuch-durchfuhrung-quapsss-gruppen*

Epidemiology

According to a statistical survey conducted in 2017-18, more than 50% of MSM reported having used GHB/GBL, 47.8% amphetamines and 2% mephedrone in the preceding 12 months. While not all of these uses fall under the heading of chemsex, 15% of those questioned said they had already practised chemsex, 9.5% once or more in the last 12 months. This practice is found in all the country's largest cities: Berlin, Cologne, Nuremberg, Düsseldorf, Munich, Frankfurt and Hamburg.

“We fuck with guys we would never fuck with, if it weren’t for drugs or even alcohol. Actually, we don’t care... We don’t care, we see an ass, we see a dick... that’s it. In sex with drugs, you don’t care about the person.” Philippe, 49 years old

Chemsexers’ testimonies

Verbatims – collected for the Apaches studys (OFDT*, 2019), coordinated by Maitena Milhet, sociologist and researcher in the French Observatory on Drugs and Addiction Tendencies’ (OFDT) TREND and Public Policy Evaluation units.
Interviews – by Charles Roncier vih.org.

* *OFDT, Observatoire français des drogues et des tendances: French agency monitoring drug use and addictions.*

"I was with someone I've known for a while, so I trusted them. But the moment I did the injection, I felt my whole arm burning, so I immediately took the needle out and stopped. And I thought: 'Never again'… I had that feeling… there's really that fear too. I thought: you don't realize how risky this is, if it burns like that just there, what can it do if it's inside you? That's it, stop, enough of this shit." Dimitri, 45 years old

"If you say to a guy: 'you're shooting up' or 'you're fixing', he'll take it badly. If you use the word 'slam', it's fine. Slam. S-L-A-M. There. But if you define the same thing with the word fix or shoot, suddenly, you have this image from the 80s, of an old junkie whore with no teeth left. But it's the same, and the result, in the end, will be the same. It really gets on my nerves. This hypocrisy."
Sabri, 43 years old

"I like making people feel good. So I'll offer them more stuff to take, more G; I go get them a drink. I also recruit, I spend a lot of time trying to get people to come, on apps, contacting people, waiting for people to contact me, maintaining the momentum… Ultimately, I'm not really someone who has a lot of sex. But I like this social context, I like taking chems too… It's really a context where it's just feeling good to be together."
Vassili, 32 years old

"I started slowly, and one day I found myself with people who used intravenously. I refused to do it, I thought: 'No, I could never do that to myself, inject poison…' Then I realized sniffing was very unpleasant for my nose, it made my nose sting and burn, it was very unpleasant and I had a friend who also uses, and we were together once and he is someone I really trust and he said: 'Do you want to try?' I said yes… It was really very very different… Soon, in January, I'll have been injecting for two years. And it's true that there is something completely different about it. First, the reaction is much faster than with sniffing and… And the effect is far stronger. You could say the effect is almost tenfold compared to sniffing." Bastien, 64 years old

"The immediate thing is: ah! You want to get physically close to someone. It's a thing that makes everything feel more intense, and you want to be cuddled, you want to be fondled, you want to be in contact with them…" Nabil, 35 years old

"It's me that does the dosing; keeps track of time. Whether it's at my place or anywhere else. I don't want to find myself in a situation where there's an accident… As soon as I arrived, I'd tell them, 'Listen guys, I want to have sex with you, but we'll be disciplined with the drugs.' I didn't want there to be an accident because sometimes I saw guys completely out of control… so I prefered to play nurse and keep track on my phone. I would set a timer for an hour or an hour and a half before taking more… You do the dirty work. It's work no one wants to do. It's worth it."
Fabien, 37 years old

"There was an investment banker with a young student and even a waiter from a gay bar, there was a real mix. ***Blacks, Arabs, whites like me. And I thought: wow, that's so beautiful, just that*** *(…) Sometimes I have sex, sometimes I don't, but I watch. I'm content with whatever. I like watching people… seeing people hug, meet up… I think it's quite poetic, and if at a party I don't have sex, I won't think: oh shit, I didn't have sex."* Jean, 25 years old

"I started using drugs when I was 27… ecstasy, stuff like that, but in more of a party context… I had moved to Montpellier, I started going out more, so we took drugs to go out, to have fun, and since we felt more free, completely uninhibited, we had more sex, but the aim wasn't necessarily to have sex. (…) And then the new drugs appeared and that… Actually, it shifted from partying to sex, then to just sex, and there was no more partying. It's just sex. The aim is sex."
Philippe, 49 years old

Michael, 28 years old

> *What pleasure do I get from chemsex? I think it helps me remember things better. You really remember the scenes, people, and sensations. I like the state it puts me in. And it feels good; the way it feels is really great.*

I started doing chems during the first lockdown. There were quite a lot of parties, and I was living alone in my flat in Paris. I wanted sex and I was frustrated. To begin with, I mostly did chems at after-parties. I'd go to parties and clubs and then on to group sex. I think a lot of guys my generation started like that.

Later, I began buying chems, and it's dangerous to have them at home; as soon as I get home, I can very quickly start using all alone. And when I start using alone at home, I know I'll be off for a while. I'll go to a sex party fairly soon. Basically, they get me started. I try not to buy chems, so as not to have any at home.

A year and a half ago, I was seeing a guy, well, we were sort of dating, and he uses a lot. With him, my use got worse. Then I got sick; I have several conditions that make me very tired. I'm really very frustrated, and using makes me feel alive.

That guy dumped me. At the time, I was really using a lot, even on weekdays. I'd even sometimes take chems to go to work. Not for the pleasure, it's pretty hard to concentrate. Once I start 3-MMC, I can't stop.

> *It's really hard to set limits; the drugs are so easy to get, it's as if they're everywhere. On Internet, on Grindr quite often, at least at the weekend, there are lots of offers with a rocket emoji or people selling on Grindr. On Telegram too, I've bought from several people.*
> *I tell myself: you have to block the numbers. But I buy again! Sometimes I get offers by text messages. It's super easy. And although it's a little more expensive than it used to be, it's not that expensive.*

I feel like using allows me to experience all my sexual fantasies. I think I do things I wouldn't have done sober, a bit like with alcohol. When I started having sex, I was a bit scared of it, I thought it was for other guys, not for me. Now, after a period with a lot of sex on drugs, I'm realizing I have a weird relationship to sex. I've been in some pretty grim situations. Guys who are really into dark things, guys who are bleeding. I saw a guy being fisted, bleeding, and the other guy kept going. But had he really been told to stop? I think I've had sex with guys I wouldn't have had sex with otherwise, and they probably felt the same.

I don't have a serene relationship with chemsex because I feel it has become embedded in my sexual fantasies. Lately, I've even masturbated thinking about the state I'm in when I use. I've scared myself several times. I've ended up completely exhausted after a weekend of fucking, using Tina, and needing to take 3 days off because I really wasn't well. So I'm trying to use less. Also, because I want to live a long life: around me, I see people who have been using for a long time, and it shows on their faces. They look really worn out, even if they're young. I'm scared of dying at 45.

There are people I know, on Grindr, I see them every weekend, online from Friday night to Monday. Particularly a couple of guys that live near my place. Their flat is filthy, but they keep at it, it's a bit disgusting.

I think my situation is a bit unusual: my friends don't use, only my sex friends, and they have no contact at all with my regular social circle. When I go out with friends, it takes over my brain, and I switch to autopilot, especially if I've had a bit to drink. All I want is sex, so I leave the party early, without telling them.

I think I want a complete change of life. My friends have made comments that have scared me a bit, and I want to value other moments. After New Year's, I tried to see an addiction specialist that someone recommended, at the Marmottan Addiction Clinic. The person was nice: when I told her I wanted to use less or maybe stop, she said my life needed to improve. That you can't just stop stuff like that, there has to be something in your regular life that is better than the drugs. But then I was stood up twice, so I stopped going. I think there's a thing with social class and very different social contexts at that place. The people in the waiting room come for other problems; there are a lot of really deprived people. I think it can put some people off. And also it felt like they weren't taking my problems very seriously.

Now I heard about a place in the 14th arrondissement, Cassini. I have an appointment in three months with a nurse. It's pretty hard to find information when you're not really inside the health system. I heard about a non-institutional group on Instagram called Chemspause; they post messages on Fridays to support each other. That's not bad, in my opinion. I also got an email about self-organized, supportive queer sex weekends, with limits. But I haven't tried yet."

“I felt like I was really giving myself to the other person, like a gift. And so were they. This feeling of time standing still, like you’re in a kind of space/time bubble… I looked at him, he was even more handsome, we kissed, there was this whole thing. I could feel every tiny vibration in his body.”

Fabien, 37 years old

“Usually, group sex is always without condoms, so there’s no real concern about knowing a person’s serological status or if they’re on PrEP or anything. It’s really, above all, about trying to have sex without condoms.” Rémy, 28 years old

"Before, at high school, my homosexuality was pretty complicated to deal with. I was marginalized. I was marginalized because I was homosexual. I also come from a very traditional background on my father’s side, of Moroccan and North African origin. When I came out I was 14 years old, I was kicked out of my mother’s house, I spent a year and a half in Morocco where, basically, my father’s proposition was: either I kill you, or you change (...) For me, that opening was a liberation like a pressure valve exploding... My first slam was very powerful, like a kind of discovery. For me, it was the beginning of a kind of total sexual liberation.”

Tom, 22 years old

“THE PROBLEM WITH CRYSTAL (METHAMPHETAMINE) IS THAT THERE IS NEVER ENOUGH OF IT. YOU ALWAYS WANT MORE, WHETHER YOU’RE ACTIVE OR PASSIVE, AND YOU’RE NEVER SATISFIED, THAT’S THE CRAZY THING. YOU CAN FUCK FOR HOURS AND HOURS, YOU’LL ALWAYS WANT TO KEEP ON FUCKING, AND YOU WON’T BE SATISFIED.”

Armand, 52 years old

"I got to a point of sex and drugs overdose, that's why I stopped. Like a friend who said to me 'I'm tired of being treated like a dick and such like' and it's true that... at least for me, it was the sex overdose that led me to this... I was sick of spending every weekend, of being comatose every Sunday because I was completely out of it, of not being able to move forward and of doing nothing with my life. It takes away any passion, it takes away everything." Hervé, 31 years old

> I started using chems more than ten years ago. A few men had asked me in the past if I wanted to try, but I always said no. I started because of a serious injury in the rectal area. The pain didn't want to go away, it was hurting, so I thought, let's see what happens with chems. And, in fact, it didn't hurt any more. So, that's actually the reason I started using. At the beginning, it was once a week, on the weekend, because I was still a young student during the week.

It's a sex drug: you feel so much energy, and you feel very horny. You can only think about sex when you're high on that. It's different from the other drugs I tried, like crystal. It's very much relaxing at the same time. I'm quite cute, so I don't have any confidence issues, but if you do, it'll make you very confident about yourself. And you feel more sensations, you're more sensual.

First, I have to tell you: I never get addicted. To anything. Some people get depressed the day after, but I've never been depressed in my life. Not even when my father died. When it's over, I'm in such a happy mood, I just go home, and I can work and study normally. I don't have any issues with sleep or food, even after using a lot. If I want, I can take chems the whole week, and I can still have other plans with my friends or dates or everything.

I can use a lot, like six grams of 3-MMC for a day and a half. Many people are surprised with how much I can take without issues. I used to work at 10 o'clock on Saturday morning, as a cashier. I did it for a few years and I never had a problem, not even once, calculating the change. And I used to do the last take at 7 in the morning.

I've never bought chems in my life. I never paid for it and I don't use alone. There was a time I had some at home, for several years, but I never used it, and I just threw it away after a while. What's the point of taking it alone? It's for having sex. It's like taking MDMA. I know some people do it alone, but it's better in the club.

If I have plans, I'll try to not use, because it makes your skin look very bad the next day, and you don't want to meet with your friends when your skin is bad. I don't plan to do chems, I just check my schedule, like if that Sunday I want to go to an Indian Festival, so I'm not free that day, but I can take a little bit of chems the day before.

> I don't smoke, I don't vape. When I take chems, I don't drink. That's my rule. I have a very good health, and I can tell what my body needs or not, even with food. I feel like chems and alcohol are not a good match; it doesn't add to the effect, but I will feel tired the next day. And I hate feeling tired. I actually think the good way to do it is to not eat for the whole day, and start partying with the chemsex, not alcohol.

Because when you don't eat, a little amount will go a long way. When you eat too much, the effects are very slow, and you need to take quite a lot.

I used to slam, but I stopped a while ago. I used to do it a lot. I think the first time I slammed was in 2016. Honestly, I will never stop doing drugs, or slam, or anything.

But I agreed to pause for a while, for a friend, who insisted. I decided to stop for him for a while, a few months, maybe until the end of the summer. But I'm not going to stop forever.

I had a boyfriend for a while, he doesn't like to use drugs, he doesn't even drink alcohol. So I didn't do drugs when I was with him, for something like five years. And now that we are on a different road, I started taking chems again. The most I used this year was five times a week, but it's usually two nights in a row. I didn't take much last month, because I was traveling around, and I had some friends visiting me in Paris. I didn't have any time for that.

I can't tell you how other people feel about the drugs, I'm not in their heads. But I can tell you a few stories. What you have to know is that chems are free for us, young guys, because there's always a group of older men, from 40 to more than 60, often steroid users, that buys chems in bulk to party. They rent a flat and invite only young people, from 15 to 21 max, all white or Arabic. No Asians or Africans usually. This happens quite often, and I guess for many guys that's how they start taking chems, not knowing what they are doing. I've seen that a lot, with young Asians or South Asians like me too, they get offered drugs and they forget about the future they wanted. It's quite sad.

But it's not just the young people. I know a few people that decided to kill themselves after 30. When you're used to men giving you gifts, money and attention when you're young, it can be hard when it all goes away. It's a small world: you can't lie about your age, everybody knows, you'd have to switch cities. The less attention you get, the older you feel. Their life has no meaning, and some choose to commit suicide; others just take too much drug and then die.

Last year, I met a guy. He was cute and he had a normal job, a good one. We went to a home party and he slammed for the first time, despite him having told me before he thought it was disgusting. A few weeks after, his arm was covered with marks from injections. The drugs didn't work anymore, but he kept doing it, and I told him he needed a rest. It happens to me too, and when it happens, it feels like I have to pause for a bit. I don't understand why people keep doing it if it makes them feel bad. I don't know really how it works, though.

Peter, 27 years old

Christian, 62 years old

> *I started taking drugs at a very early age. The first time my brother gave me a line of coke, I must have been 13 or 14. And yet I'm a good citizen. Drugs were present early in my life, though not necessarily in an intense way. My wife tells me that I've always done a bit of drugs. Yes, I'm married. But I sleep with guys.*

I've always loved new experiences. I loved hallucinogens, empathogenic stuff like MDMA. Once, in the United States, following a plan on the internet, I smoked meth and I found the experience incredible. I didn't sleep for three days, and after that, of course, I had to be peeled off the floor...

I started wanting to try stronger and stronger stuff, maximum experiences, like injecting myself. In 2017, I was 56, just the time when the body is no longer the same, when you take refuge in a self-image that's no longer relevant. The sensations — or at least the illusion of sensations — that these drugs provide meant that I fell for them very, very quickly.

I'd heard about this new drug, 3-MMC. The first time was with a guy I found on Grindr, and I found it incredible: an absolutely inimitable tactile sensation, a contact, the other person's or your own with your skin, that was simply magical. The cathinones begin by giving you a flash, like a kind of orgasm all over your body and mind. Well, the first time. After that, it's all about the quest for that first time.

I wasn't too keen on ordering on the internet. I wanted to buy 10g. It's quite a large quantity, but it wasn't expensive at that time. My first two orders didn't arrive. I complained, and in the meantime I ordered from a third site. In the end, I received the first two orders, with another package to compensate me. I ended up with an industrial quantity of 3-MMC, and thus, the addiction.

It's quite a special experience, but in terms of quality, the 3 is full of flaws. You have to take a lot of it again. Tolerance builds up really quickly compared to other drugs. I've seen late-night situations where people haven't been doing anything for a long time, but they keep trying to shoot up, without succeeding. The last few drinks were useless.

Chemsex drugs are psycho-addictive, but not physically addictive. When you stop, you're not physically ill, you're managing. It's in your head, it's much less palpable. Basically, it's a huge release of dopamine or serotonin from the product. Then you get a big low, and during that big low, you want to start again.

I was making shots with several people. You go on dating apps and guys are looking for a "high" as they say, or "gliding". There are those who take 3 and those who take coke. They're not the same. Where I live, there are quite a few married guys hanging out in the woods, or getting laid any way they can... And there are quite a few of them who take drugs and go home in a state...

The number of times I've gone home totally stoned, driving crazily, on small country roads. I lost a lot of points on my licence at the time, but I never had an accident and I was never stopped. I was extraordinarily lucky. Or in fact not lucky, as it might have helped if I'd been checked.

When you start out, it's kind of romantic, you get an illusion of community. It's a feeling of hedonism, almost. It gets sordid much quicker than you think, but you meet people from all walks of life, just like on dating apps. Married people, young people, sportsmen, and so on. There's no social barrier, you feel like you're sharing this kind of ritual and then the sex.

Maybe subconsciously I was looking to meet people, to make contact, but I also loved the very anonymous quick sex. It's a contradiction in terms. In any case, the illusion doesn't last long, because people steal your bag or your things. The community feeling is a sham.

It was really just booty calls. Out of necessity, I had a few contacts in the area. I know there's a guy 12 kilometres away who logs on to Grindr from time to time. I can count on him to make

plans. He's my age. He had a heart attack in the middle of a session. He was with a guy who bent over backwards for him, but he kept cheating on him and spending lots of money on drugs. He was backed into a corner, just like me. Often, the saving grace is that there are people who love us.

After I started slamming, I didn't use any other method of consumption. I had an operation on my arm because I'd caught some really nasty infections. They didn't cut my arm off, but they could have... It's more the idea of the injection than the product that appeals to me, I think. The product is important too, of course, but opiates, for example, aren't my thing.

> *The first trigger was at the end of 2017. I was in the centre of Paris, in a sleazy hotel, with a guy who didn't give me much grief and who was quite concerned about drugs himself, if his condition is anything to go by. We had a bit of a chat, family and all, and after a while, in the middle of sex, he said to me: Does your daughter know that you're a drug addict? It was the first time anyone had ever told me I was a drug addict. I continued to ignore the idea for a few months, until the impact on our finances became apparent: I'd switched to meth, which costs 220 euros a gram. 3 is 12 euros a gram. My wife, who does the accounts, couldn't understand what was going on. I admitted: "I'm in deep shit, I'm a drug addict." I promised her I'd stop. I continued until the spring of 2020.*

At the beginning of 2019, I no longer had a professional credit card. I had used mine too much to make withdrawals that I could no longer pay back. That also helped calm me down. There were times when I used to get high in the office, just before meetings, in the toilets.

In August 2019, after several months of holding my own, being clean, I organised a chemsex episode in my own home. I found myself on my own one weekend. The dealer sent a promo message and I cracked. I reactivated the dating apps and that evening there were four people in the house. It was a total mess, and it almost turned into a tragedy. And there were consequences with the police, because a guy was found naked in the street with my phone. I got a simple warning, but it scared the hell out of me, so I told my wife all about it.

At that, she said to me: You do it again, you're out of here. I crashed once more. When the lockdown started, I packed a suitcase and went back to my parents' house. They're a big, very traditional family. When you're an addict, all you think about is yourself. I was less present and attentive to others, less helpful, I had to explain to them. But they didn't pester me and were very supportive. After a month, I was able to return home in the middle of lockdown. My wife and son wouldn't speak to me...

When it comes to addiction, social and personal factors play a huge role. During a training course, a coach told me that I needed to look after myself and recommended the EMDR (Eye Movement Desensitization & Reprocessing) technique to resolve old traumas. The therapist in my neighbourhood wasn't competent, and I sank into depression. Three months later, I was addicted. It was a time when I felt guilty for what I had done and was continuing to do to my wife, and guilty for not having the courage to be completely gay.

I'm still working, but I'm off sick. I had a very stressful job. It's been a real descent into hell. I could see myself becoming homeless. I'm no longer making plans. I made a commitment not to cheat on my wife.

It's a miracle that I'm still here and that we're still together. It's very tough. There are a lot of lasting wounds to repair. But everything is on the table. I'm seeing an addiction specialist doctor and I'm having psychoanalysis, which is helping me much more than anything else. Addiction specialist doctors prescribe things to replace psychoactive products with other psychoactive products, like antidepressants.

The problem in France is that medicine is not holistic. We see doctors by symptoms or by type of illness, but no one ever looks at you in your entirety. We should be told: read, garden, run. I said to myself: if I'm going to survive, it has to be in a more comfortable way.
So I started walking.

"It's extremely easy.
It's shockingly easy. That's also what's difficult. Because if you want to live differently, you really have to reorganize your life. For instance, I hadn't been on Scruff for a long time. I went back yesterday, and within less than an hour, at least three guys offered, for free, easy..."

Sabri, 43 years old

"I admit it completely loosened me up. Completely torrid fantasies, completely uninhibited. Chems made that possible for me, especially fisting. Slightly 'dom' trips, things like that."

Frank, 37 years old

"I set two rules for myself about using: not during the week, not alone… I don't want to do chems on weekdays. I never use the apps on weekdays. I don't want to put myself in a situation where I could crack. I save it for weekends, so I can keep up with work commitments." Vassili, 32 years old

Brussels: a patiently elaborated system

Christelle Destombes

In Brussels, HIV organisation Ex Æquo has expanded its community services to better address the issue of chemsex. Beyond providing support for users, it leads Brussels' Chemsex Network and trains healthcare professionals in approaching the phenomenon. Today, while maintaining a community-based approach, Ex Æquo is considering creating a medical centre. Swaps met with Stephen Barris, the coordinator, and Arturo Mazzeo, the health and chemsex project manager, under the high ceilings of the Grands Carmes.

Arturo Mazzeo and Stephen Barris, © Ex Æquo

In the heart of Brussels' gay neighbourhood, St-Jacques, the community healthcare organisation Ex Æquo occupies 2,300m² in the "Grands Carmes", a 17th century building currently being renovated. The idea, supported by the Brussels Municipality, is to create a space for the LGBTQIA+ community, with organisations such as Genres Pluriels, Tels Quels and the Rainbow House. In what could become the biggest LGBT community centre in Europe, the main component will be a medical centre, the MACS, or *Maison arc-en-ciel* de la santé (Rainbow Healthcare Centre). Stephen Barris, who coordinates Ex Æquo, explains that the goal is to balance "a community approach based on peer support with the introduction of healthcare professionals". This development is partly an adaptation to the chemsex issue, which has led the organisation to broaden its range of services.

A broader range of services

Ex Æquo was founded in 1994 to provide equal access to healthcare for the gay community. It has since branched out to other areas as the HIV landscape evolved. "It is primarily a community organisation, a peer organisation operating on the principle of gay meets gay, with a base of 150 volunteers, 80 of whom are actively engaged", says Stephen Barris. "Relatively speaking, it is similar to Aides, the big French NGO, but our budget is only 400,000 euros per year, and we have five employees for all of French-speaking Belgium."

Ex Æquo started conducting prevention campaigns on drug use in sexual contexts as early as 2007, particularly to reduce infectious risks. Ten years later, Ex Æquo took decisive action. "Volunteers told us about chemsex, and in 2018 I attended the Chemsex Forum organised by Ben Collins in Berlin (cf. pp 55). I realised we needed to act, to create a pragmatic, non-judgmental programme." The first step was to inform users: chemsex.be was created, inspired by the Terrence Higgins Trust's Friday to Monday website (https://www.fridaymonday.org.uk/), with an encyclopaedic section on drug use and harm reduction, and a directory of organisations and services (https://chemsex.be/aide/) that address addictions.

The chemsex.be website has become a reference for the French-speaking population, with nearly 140,000 page views per year. Ex Æquo also opened an online store to order free harm reduction materials, whether sexual or drug-related (condoms and gel, pipettes to dose GHB, injection kits, containers for infectious clinical waste, snorting kits, etc.). A support group, *Let's Talk About Chemsex*, was created in 2018, inspired by David Stuart's group in London. It now meets in Ex Æquo's premises and has become part of the "chemsex programme". In March 2020, an agreement was signed with Infor-Drogues, allowing chemsex users to have consultations inEx Æquo's premises upon request. Clinical psychologist Maurizio Ferrara conducts these consultations. They were fully booked in just four months, with 12 regular users. The Covid lockdowns in March 2020 meant support groups had to take place by video. The first training course for healthcare professionals on providing care for chemsex users, was organised in 2021. Ex Æquo leads an informal Brussels chemsex network, where professionals can discuss and share practices.

Becoming a psychologist

Arturo Mazzeo, a clinical psychologist and psychotherapist specialising in mental health and chemsex, manages the Network: "We coordinate to offer long-term care, discuss clinical issues, and share experiences." At Ex Æquo, he is in charge of reception for chemsex users, with a small team of four people, who can refer users identified via the WhatsApp group. Product testing is organised with the NGO Modus Vivendi. Mazzeo also co-hosts a chemsex support group on Thursday evenings with a peer health worker and offers individual follow-ups for certain users, thanks to federal government support facilitating access to mental health care.

"Ex Æquo today is identified as the only organisation to address chemsex on both clinical and community levels with a non-judgmental approach", he explains. Attendance at the support group is variable, with participants coming more or less regularly, but "the groups are becoming more solid, they have settled into a rhythm". Discussions are open, but Arturo Mazzeo's "psychological listening" helps underlying issues come to the surface. "To avoid participants focusing solely on drug use, we explore what lies beneath: loneliness, their relationship with the community, discrimination within the LGBT+ community or the MSM community, childhood trauma… all these topics can be discussed. Part of treating addiction is to put the individual at the centre of their story and, through peer exchange, they feel less alone in their suffering and learn how to cope with certain psychological aspects."

Mazzeo, like Maurizio Ferrara and other chemsex psychotherapists, deals with the most problematic cases, people who come seeking help. Ex Æquo proposes 8 individual sessions, and can add 20 more if needed. Users can also be referred to hospital care, for rehabilitation or long-term treatment. The centre is open from 10 a.m. to 5 p.m., Monday through Friday, and now addresses substance use in sexual health counselling. "Once you start asking about chemsex, you realise how big the problem is", admits Stephen Barris. "Before, in an HIV approach, we didn't ask about chemsex use. Making the issue visible identified us as a place where you can start talking." On the thin line between community management and being accused of proselytism, particularly by certain commercial establishments opposed to distributing harm reduction material, the Ex Æquo team feel like they're inventing a flexible response. "This practice, at the crossroads of sexuality, homosexuality and drug use, made addiction-focused organisations uncomfortable, as they found it difficult to talk about homosexuality with chemsexers. These structures need to learn how to welcome homosexual users. And we, as a community organisation promoting health, are learning to welcome people who use drugs."

Training Professionals

Ex Æquo trains professionals on-site, in university hospitals, psychiatric hospitals and family planning centres. Arturo Mazzeo is in charge of this: "I combine several dimensions: harm reduction, the history of the community, substance use, mental health, clinical practice… I try to help professionals understand how

The Impact of Covid on Youth

In Brussels, as in other European capitals, the Covid period exacerbated the chemsex phenomenon and saw practices become more and more problematic. Arturo Mazzeo explains: "A large number of young people started chemsex to join a group and meet community members during lockdowns. Some found themselves trapped in this practice afterwards. For those who were very isolated, especially in rural areas, it was an explosion."

Brussels is a cosmopolitan city with many young people who move there to study or work, ending up finding themselves all alone. "During Covid, apps were the only way to get in touch and secretly meet people, and the LGBTQIA+ community were even more vulnerable with regard to facing isolation. There were a lot of 'chills' then, as chemsex get-togethers are called in Brussels." It is difficult however, as it is elsewhere, to assess the size of the problem. The current estimate is that one in four PrEP users (6,000 in Belgium) use drugs in sexual contexts… But not all gay men take PrEP, and not all chemsex users have problematic using habits.

to better address users' suffering." Often, trained professionals join the Chemsex Network. In collaboration with the General Practitioners Scientific Society, Arturo has set up online training modules for general practitioners (cf. p. sq.), that will soon be extended to providing access to the training modules for psychiatrists as well. For both activists, the issue has become more pressing with the increasing number of deaths and a certain "normalisation of drug use in sexual contexts", according to Stephen Barris. "But the programmes are fragile. We're not funded or sufficiently equipped to face up to the phenomenon. The aim is to create an institutional response to this problematic drug use. Today, our goal is 1) to get people informed, 2) to help them come out of drug-using sessions in as good a state of health as before they started, and 3) if they're struggling, for them to know where to seek help. For people who are overwhelmed by their drug use, making sure they are not isolated, that they know where to go, is a community response."

Harm reduction material,
© Ex Æquo

Ex Æquo and Community Health

In Belgium, health promotion is a regional responsibility. Ex Æquo receives funding for HIV and STI prevention and drug-related harm reduction from the Brussels-Capital Region. Covid prompted the federal government to improve mental health funding, thus allowing for psychological consultations.
In 2017, after adding healthcare professionals to the team, to do comprehensive sexual health check-ups, Ex Æquo hired one psychologist, then another, for chemsex. "This is completely new", insists Stephen Barris. "A community organisation has included doctors in a sort of triangulation made up of a peer health worker volunteer, a user and a doctor" He hopes the chemsex programme will secure national funding as a support programme for people with addictions, and be officially recognised as a medical centre, with 16 consultation offices, including a gynaecologist, a dentist and a physiotherapist. If so, it could open in 2029.

Ex Æquo

22 rue des Grands Carmes, Brussels
exaequo.be
5 employees, 80 volunteers
Chemsex support group: Thursday evenings at 8 pm
Email: info@chemsex.be

The right training

Arturo Mazzeo / Health and chemsex project manager Ex Æquo

Clinical psychologist Arturo Mazzeo presents the training courses he has set up to raise awareness among healthcare professionals on the "subject" of chemsex, which is not always a "problem".

There is a risk of making an issue of a phenomenon that is not necessarily an issue for all users.

Since June 2022, Ex Æquo has been offering a new chemsex training course covering both the historical and socio-community aspects of chemsex practices and the psychological aspects that support continuing these practices. The course consists of two modules that are given separately or together, for a total of three hours training. The first part of the course looks at the definition of chemsex and the need to use this term for the MSM and LGBTQIA+ community in general. The module then takes the audience through the history of chemsex and how it has evolved up to the present day. It provides an opportunity to share what we know about the substances most commonly used and how chemsex encounters are organised and carried out. It is necessary to be able to share important details of the "chills" with the target audience of our training courses to emphasise the extent to which the community and group membership aspects are an important dimension of these encounters. The second part of the course draws its inspiration directly from clinical practice with users, both in individual interviews and in group sessions. Drawing on the international literature and scientific research in clinical psychology and psychoanalysis, we highlight the social and individual vulnerabilities that users reveal in their personal and group work. Childhood abuse, sexual abuse, rejection, discrimination and loneliness are all part of the picture for most of the users who get in contact with us.

The training targets all professionals in the psycho-medico-social sectors, and sharing our expertise on this subject is proving to be invaluable for organisations or groups of professionals that are increasingly confronted with this issue and/or this subject. This last distinction is important because there is a risk of making an issue of a phenomenon that is not necessarily an issue for all users. This observation allows us to warn participants about the risk of treating this subject with users/patients in a stereotypical, violent way, with the risk of failed care provision (whether for questions about drug use or any other related question, such as a request for screening after a "chill") due to a breakdown in the trust relationship with the professional being consulted.

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A growing cooperative network to support chemsexers

Interview by Tim Madesclaire for *Swaps*

In Lisbon, chemsex came to public attention in the middle of the 2010s, when problems related to it became apparent. In a legal context of drug use being decriminalised and harm reduction well developed, solutions rapidly appeared, connecting a public program, DiverGENTE, and community responses from historical organisations, such as Kosmicare for harm reduction and GAT, for sexual health; and a growing cooperative network, as explains Filipe Couto Gomes, a psychiatrist in Lisbon for the community organisations Kosmicare and GAT.

***Swaps*: When was chemsex identified in Lisbon?**

Filipe Couto Gomes: The use of mephedrone by MSM in sexual contexts was identified in Lisbon between 2010 and 2012. Cathinones became commonplace during this first period. However, the first harm reduction initiatives were only set up around 2018 or 2019, along with referrals to support services that provided specific clinical approaches for people involved in what we understood to be chemsex. This was in response to the increase in serious consequences related to substance use: logically, more requests for support, due to loss of control, ensued.

***Swaps*: How do you define chemsex?**

FCG: Here, "chemsex" is used by the people who are directly concerned of course, but to begin with it was used by the services that were set up for them and by LGBT and mainstream media. We thus define the word in reference to the users who are asking for support: mainly they are MSM using cathinones, GHB and/or methamphetamine for sexual purposes, in a variety of contexts. Users of other psychoactive substances (ketamine, cocaine, MDMA…) and who are not MSM (trans and non-binary people, cis women, men who don't have sex with men) are less present in these services. For chemsex services in Lisbon, the first definition to be relevant was provided by David Stuart in the United Kingdom[1].

[1] *Stuart D. Chemsex: origins of the word, a history of the phenomenon and a respect to the culture. Drugs Alcohol Today. 21 Feb. 2019;19(1):3-10. David Stuart defines chemsex as intentional drug use to facilitate or intensify sexual relations, often in a context of prolonged sexual activity, involving more than one partner. He points out chemsex is specifically connected to certain substances, such as mephedrone, methamphetamine and GHB/GBL, and is particularly present in certain communities, such as MSM (men who have sex with men).*

***Swaps*: What recent evolutions have you noticed: new uses, new substances, new users?**

FCG: Since the 2020 and 2021 lockdowns and then international tourism resuming in 2022, chemsex has been on the rise in Lisbon and in Porto. Chemsex now involves a growing and heterogeneous group of MSM: residents and tourists, of different ages, from different economic backgrounds and countries of origin, with a strong representation of people living with HIV and a significant number of sex workers. Drug use habits with regard to cathinones and GHB, with or without sex, have also multiplied: these substances are not only used at private parties and in saunas, but also among groups of friends, at the beach or at alternative queer parties. Chemsex in Lisbon now includes other substances, such as different subgroups of cathinones, methamphetamine, ketamine… This period is also when intravenous use, or slam, began to appear.

***Swaps*: How is chemsex talked about in Lisbon? How is it perceived by users, community organisations and health and harm reduction professionals? Is it only seen as a problem, or is there also space to express positive or less problematic experiences?**

FCG: The way users themselves talk about chemsex demonstrates its complexity: the intense experience and

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Filipe Couto Gomes

pleasure, but also the difficulties they encounter, the "everyone's doing it" pressure. I think discussions about chemsex are probably more positive when it happens with friends or on the alternative queer scene, than in casual encounters through dating apps or at private parties or saunas.

But usually discussions about chemsex focus predominantly on the most difficult experiences, on people in the most difficult situations, and when complications appear. Health services naturally concentrate on the requests they receive: difficulties keeping use under control, wounds and toxic effects, sexual violence, problems with mental health, difficulties with sexuality. The pleasure people get from chemsex isn't talked about, I would dare to say, but experienced: it's the difficulties that make people bring the subject up. And when they finally start talking, they also mention life with HIV, loneliness, difficulties getting sexual satisfaction and other related issues.

We know that many chemsexers don't have major difficulties. In 2019, we tried to raise awareness about safer ways to use, with a specific campaign, and publications in an LGBTQI web magazine. The aim was to help users identify when and how to find a space for discussion, information and support, with us. This is the only initiative that has received public funding. A brochure produced for this campaign gave harm reduction advice for safer using and contact information for harm reduction and sexual health services and for organisations fighting against sexual violence[2].

Swaps: How do users get the substances? Can they get them analysed?

FCG: Chemsexers have different ways to get the substances: either on websites, or with dealers they contact *via* social media or by phone. Some are both users and dealers. Others get the substances directly at parties or hookups. Sometimes, effectively, they are exchanging sex for substances.

They can get the drugs analysed by Kosmicare[3]. Users can bring a sample in on Tuesdays and Wednesdays and get the results on Friday, by phone or *via* a message service (WhatsApp, Signal, Telegram). The analysis is qualitative for most substances, meaning the substance is identified in the sample, but without knowing the precise amount, except for MDMA and 2C-B, which can be quantified and for which we can provide the percentage of active substance in the sample.

Swaps: A Portuguese specificity is its drugs' policy, that has focused on harm reduction for a long time. How does that impact chemsex? And in this context, how do the police behave? How do they intervene if users have a problem (OD, G-Hole)?

FCG: In Portugal, possession and use of psychoactive substances were decriminalised in 2001. That doesn't mean they are legal, though. If the police discover a network or venue where chemsex is taking place, users will have to present themselves at a "Commission for the dissuasion from drug abuse"[4], because psychoactive substances remain illicit. This commission can oblige them to seek help. If any trafficking is suspected, there can be judicial proceedings.

However, the police don't intervene when emergency services are called for an overdose. All the same, we receive frequent notifications concerning people who are unconscious, abandoned on the staircase of a building where a party is taking place, on the other side of the road or even somewhere isolated, by people who only call emergency services once they are sure they won't be identified.

Swaps: You mentioned that chemsex started gaining attention, when chemsexers began contacting healthcare services for help. How was the response to chemsex issues organised? How do chemsexers access addiction services?

FCG: Public addiction services were designed to be independent and easy to access. They were created during the heroin crisis in the 1990s, then adapted to treat

[2] *The brochure is available here: https://www.checkpointlx.com/public/uploads/banners/CHEMSEX.pdf*

[3] *Further information can be found on Kosmicare's website: https://www.kosmicare.org/checking/*

[4] *In Portugal, the use of psychoactive substances was decriminalised in 2001, and at the same time "Commissions for the dissuasion from drug abuse" were created. These commissions are formed by a social worker, a healthcare professional and a lawyer. After studying the cases presented to them, they decide on measures to take, whether medical care or administrative sanctions, which can include fines or obligations. Cf. https://www.sicad.pt/BK/Dissuasao/Documents/AS%20report%20GATEWAYS%20FROM%20CRIME%20TO%20HEALTH.pdf*

addiction to alcohol, cocaine, cannabis, gambling and video games. On the initiative of certain health professionals in Lisbon, a consultation was created specifically for chemsexers, first in an embryonic form in 2018. As of 2020, it became more structured. It is called DiverGENTE[5].

In this second phase, the consultation relied on close collaboration between two community-based organisations, Kosmicare, for harm reduction, and GAT's CheckpointLX, for sexual health. This made it easier to access. Since then, despite a recurrent lack of funding, these services have remained available, while chemsex has kept spreading and become more and more complex. Public funding hasn't kept up with the increased demand for psychological, psychiatric and nursing care, nor has it allowed for new interventions to meet the needs and evolutions related to chemsex.

Swaps: But there is a partnership between the public health service and community organisations. What exactly does this consist of?

FCG: In a way, DiverGENTE was an addition to actions already created by Kosmicare and the GAT, to form a sort of growing cooperative network. Both community organisations offered specific psychiatric and psychological consultations for chemsexers. They were given simplified access to the other services offered by both organisations: consultations with doctors and nurses to treat sexually transmitted infections, but also for slam-related wounds; substance analysis; and if necessary, referrals for PrEP and treatment for HIV and Hepatitis C.

GAT and Kosmicare community services along with DiverGENTE's addiction service are multidisciplinary interventions that bring together several structures. They also coordinate with other health services, because we realised that, in addition to DiverGENTE, an increasing number of chemsexers were going to other addiction and sexology consultations and therapeutic communities.

This program is original because of the collaboration between structures that are active across a variety of different domains, from harm reduction, sexual health and addiction, to sexual violence and support for LGBTQI people. The aim was to provide easily accessible, caring, humane services, which take into account the identified needs of people in difficulty.

As well as all this, from May 2021 to September 2023, we organised ChemTalks. These were personalised online sessions for peers to share about abstinence, led by a peer health mediator who had experienced chemsex himself, and a doctor who was also MSM. These discussions took place every fortnight and were accessible by registering. They stopped in September 2023. Initially, because after three successive sessions, we had no participants… We decided to rework the model, but ChemTalks receive no funding; they depend on the availability of the only health mediator working on the subject, and require preparation that is compromised by the two previous points.

Swaps: But chemsex has brought about new responses for harm and damage reduction, that DiverGENTE embodies?

FCG: Chemsex revealed the necessity to include peers in interventions, to invest in counselling and access to harm reduction equipment, to integrate knowledge about sexuality and LGBTQI people, and to create responses that take into account both harm reduction and sexual health services. However, two further aspects cannot be overlooked regarding chemsex: firstly, sexological evaluation and intervention, including therapy, and secondly, being particularly vigilent with regard to psychological trauma, and being able to provide care, given the frequent experiences of stigmatisation and violence, particularly with regard to sexual and gender diversity, living with HIV and sex work. Lastly, we need to keep learning more and more about the substances, from the earliest, such as methamphetamine and GHB, to the most recent, cathinones, to improve both prognosis and pharmacological interventions.

Swaps: How will the situation evolve in the next months/years? Are you optimistic or pessimistic, and why?

FCG: Ten years ago, in Lisbon, we thought chemsex and slam were exotic phenomena that would only exist in big cities like London and Paris. Today, chemsex is a daily phenomenon for people who work in sexual health care for MSM in Lisbon. Methamphetamine and slam were rare in 2019, and that changed in a few months. What will help us anticipate the years to come, is to understand what's happening in cities where chemsex is already having more of an impact than in Lisbon. In the future, we may well need to provide help for addiction and serious illnesses, even death, on a much larger scale than today. New substances could replace today's, just like mephedrone which was replaced by other cathinones, and like methamphetamine, pyrovalerones (a subfamily of cathinones) and ketamine becoming popular. All the difficulties weighing on the mental health of LGBTQI people and people living with HIV contribute, in my opinion, to the increasing challenges related to chemsex.

[5] *Cf. Cristiana Vale Pires, Filipe Couto Gomes, Joaõ Caldas, Mar Cunha, Chemsex in Lisbon? Self- Reflexivity to Uncover the Scene and Discuss the Creation of Community-Led Harm Reduction Responses Targeting Chemsex Practitioners. Contemporary Drug Problems 1-19, 2022.*

London: a community response in need of reinvention?

Christelle Destombes

When chemsex appeared in the middle of the 2000s, the British health system's particularities produced an exemplary community response. The word "chemsex" itself was coined in London, by gay activist David Stuart. First a volunteer then a staff member at London Friend, Stuart, who died in 2022, was a driving force at the famous 56 Dean Street clinic in Soho, an inspiration for all the people we met in London.

The LGBT charity London Friend turned fifty in 2022. With Antidote (run by a team of five) it already addressed drug and alcohol use. CEO Monty Moncrieff meets us in a basement consultation room. In a colourful street in Islington, a few minutes away from Kings Cross, the charity is discreet. Although a sign does indicate it is the UK's oldest LGBT charity, "providing essential support to the community" since 1972[1].

Front line

"Around 2008, 2009, we started seeing more people using crystal methamphetamine, GHB or GBL, and also mephedrone, a cathinone that was legal then", explains Moncrieff. "They told us they were using these drugs in a sexual context, in sex parties of three or more people together. That's when we started to realise something was changing. And it was a dramatic change."

Monty believes "London Friend was probably the first organisation in the UK to see this phenomenon because we had a critical mass of people from the LGBT community all telling us the same thing. This wasn't being picked up in our mainstream or general drug treatment services, since LGBT people often have difficulties when they turn to traditional health services."

In England, sexual health clinics are funded by the NHS (National Health Service). Their services are free for the public, and paid for by local government. Addiction services meanwhile depend on local government, and users can only go to a service in the borough they live in. Gay men are familiar with sexual health clinics, where they go regularly for STI tests and treatment. Monty Moncrieff explains: "We set up the first chemsex clinic in a sexual health centre in partnership with the 56 Dean Street Clinic about twelve years ago, with David Stuart, who was first a volunteer and then a member of the personnel in the Antidote team, before working at 56 Dean Street. Since then, we have worked with many clinics in different ways. Some of them prefer London Friend to hold weekly consultations; others prefer to be trained and set up their own services."

An extension of Antidote

London Friend has cared for the community's mental health for over fifty years, offering support from staff and peers – about a hundred volunteers, 25 of whom work at Antidote. Several drops-in (on Mondays for Antidote) mean anyone can walk in, chat with a peer and schedule an appointment with a professional. Several groups – for young people, trans and non-binary people, and elder LGBTs – and activities like writing and art, bring together people who are isolated. To improve wellbeing thanks to social contact is the charity's guiding principle. "What we do here is psychosocial work. We don't do medical work, we don't prescribe. We link people back into the local services that could help them."

Like other community organisations, London Friend sees chemsexers for whom chemsex has become problematic. "Maybe an overdose, or they can't remember, or an assault has happened, or they've had a new HIV diagnosis. Things are getting difficult to deal with, at work, with their

[1] https://londonfriend.org.uk/

Monty Monerieff, © London friend

The Antidote programme offers various information about chemsex

relationships, with money, the weekend is extending into the week. They need to make some kind of change. We try to encourage people to speak to us as early as possible. But generally, the people who contact us already have some kind of a problem." So, Monty Moncrieff and his team help them assess their using and goals – to stop?; to have more control? – in order to work out a care plan.

Holistic responses

London Friend offers individual consultations and also themed group counselling, like ChemCheck[2], a six-week program for people who are considering change. "With motivational interviewing techniques, we help people understand the drugs, we give some harm reduction advice. But we also help them think about what stopping or cutting down means, in order to maintain change and prevent relapses." Another therapy group, Swat, is more specifically for people who have reached their goals, or who haven't used for the entire programme. London Friend remodelled Swap (Structured Weekend Antidote Programme), that had to stop during Covid and will soon offer a 12- weekends programme, with the same principles, i.e. discussing identity, self-esteem, relationships, "sober" sex, etc. Furthermore, once a month, Antidote "clients" can drop into the centre for free STI screening.

"Very often, when chemsex becomes a problem, there might be feelings of low self-esteem, difficulties in acknowledging one's identity as gay or bisexual men, anxiety around relationships and intimacy. They may feel excluded and chemsex is a way to connect with other men. Therapeutic support can help people to understand who they are and to connect to other people", observes Monty. The recipe is tried and tested, but it does bring certain problems back into the spotlight: the need to offer a "holistic" intervention to treat addiction and also sexual and mental health, in a caring, non-judgemental manner. And also the need within the community to "change the narrative". Monty explains: "It's also very interesting that we talk to people about what they want. A lot of them tell us, 'actually, I would like to have a relationship. I'd like to have a steady boyfriend. But in London, nobody wants that. Everybody just wants sex and everybody's on the apps'. If we could only challenge that narrative a little bit, change that perception…"

[2] https://londonfriend.org.uk/chemcheck/

The entrance of 86 Caledonian Rd in London, © CD

London Friend

86 Caledonian Rd
Londres N19DN

In 2023, 372 people benefitted from London Friend's Antidote service, mostly for problems related to chemsex.
Antidote can be contacted by phone to discuss drug or alcohol use and related issues, from 10 a.m. to 6 p.m., Monday to Friday.
antidote@londonfriend.org.uk
https://www.facebook.com/londonfriend

Other programs

12-step programs are available in London, often on the initiative of peers: for instance Crystal Meth Anonymous groups, inspired by the Narcotics Anonymous model or an "LGBT Smart Recovery Group".
A new Controlling Chemsex program offers an eight-week online educational series, to inform and support chemsexers. "The aim is to touch people who have asked for help and people who haven't yet realised they could do with it", explain the course creators. It is also available in replay.
https://globalchemsextoolbox.com/

An unequal institutional response

Added to the British health system's complexity and the fact patients can't choose their health centre, the institutional response to chemsex has remained minimal. An op-ed in the *British Medical Journal* in 2015 indicated[3]: "tackling chemsex-related morbidities should be a public health priority". And the government's 10-year vision for drugs treatment has actions about chemsex, with government level support for drug treatment services and sexual health services to work together. But it's slow, points out Monty: "Ten years ago we published a guide funded by the government on how drug treatment services could better work with LGBT people. But there hasn't been any institutional follow up on those actions".

London Friend worked with ADFAM, a national organisation that works to improve the lives of families touched by drugs or alcohol. A guide for families, friends and partners of LGBT people who drink or use drugs was published in 2017[4]. London Friend also works closely with the police and their Project Sagamore[5]: "The Metropolitan Police and a probation service work together to tackle chemsex. Some of that is around criminal supply chains, but we're involved in helping them understand people's needs in terms of treatment and support".

On the dark side, London Friend is for instance in touch with a chemsex point of contact in the probation service, to work out a support and reinsertion programme. "Over 450 men in London have been convicted for an offence in a chemsex context. Some have to serve community sentences or go to prison. Since mainstream drug addiction or reinsertion services aren't adapted to this public, we're working on a pilot project funded by the Ministry of Justice, to develop individual and group support for men who have been convicted for chemsex-related offences."

This is a very new situation for Monty, who had never in twenty years seen so many gay men taken to court and convicted for their drug use. "Chemsex has totally changed the way we work, he says. It is far more complex, the mental health needs, particularly the risk of psychosis with methamphetamine, are new. The risk of overdose and dependence with G, which we didn't really have with the drugs our communities were using before. Injecting was such a taboo…" The fight isn't over and a community response is an essential part of it, according to Monty Moncrieff. "The work we do individually and in groups is unbelievably powerful, particularly group work that helps people form new bonds, and the group counselling that brings participants to a more emotional level. There is a lot of work to be done there: everyone isn't just interested in sex; many people actually want more significant relationships."

[3] *BMJ 2015;351:h5790*

[4] *https://londonfriend.org.uk/wp-content/uploads/2019/03/ChemSex-Friend-and-Families-Information-FINAL.pdf*

[5] *https://www.knowx.uk/Trophies%20(submissions)/KBT23/London-Probation-Service.pdf. A Really Queer podcast with Monty Moncrieff explains the work, and other matters related to chemsex. https://podcasts.apple.com/gb/podcast/chemsex-monty-moncrieff-mbe-yvonne-shell/id1737601299?i=1000654626199*

Helping new community values emerge

Interview by Christelle Destombes

Diagnosed with HIV in 1982, ex-drug user and chemsexer Ben Collins defines himself as an American-style left-wing community organiser, an heir of opponents to the Vietnam war, of anti-racist, feminist and gay sexual freedom activists. He has lived in London since the Clinton years, and organised three international chemsex forums, in Berlin, Paris and London where we met him. For him it is very clear: to face chemsex, the community needs to develop new values. He will defend this point of view during the chemsex forum in Munich in July 2024.

> In 2012, on a pamphlet handed out by a community guy, a tiny little notice on the back said that 2011 had seen the highest number of new HIV infections in homosexuals in the UK since the beginning of the epidemic. I was shocked to read that, in passing, on a pamphlet that was a last vestige of twentieth century style activism. I was ashamed in a way to not be aware of this, and that the community wasn't aware of it. There was a real disconnect between the community and big organisations like the Terrence Higgins Trust. They weren't responding. At the same time, PrEP became available in the United States and in France. It took ten more years for it to be available in the UK, and not even for everyone. Not all gay men have the same access to PrEP. There's still a difference in access between white gay men and the others, between men and women… Access to PrEP is stratified, racist and sexist. And community leaders have played an active role in this, by concentrating on the needs of certain gays at the expense of other members of our community. Today, facing chemsex, I feel this is happening all over again.

Drugs and the fight

Crystal started moving towards Europe from the United States in the 2000s. In 2013, David Stuart is quoted in a now famous article in *The Lancet*[1]. It was the first time crystal was mentioned in a medical journal. During that period, I brought together people who I thought were smart to discuss what was going wrong: what we risked losing without PrEP, chemsex, HCV, and the sexual and mental health issues that some of us were going through.

These discussions gave birth to our organisation *Reshape*[2]. We created it to profoundly change the response to HIV and associated pathologies, by taking into account peoples' sexual and mental state. To work on HIV prevention, we collaborated with David Stuart, which led us to launch the chemsex project in 2015. He had spent a bank holiday weekend in an Accident & Emergency department carrying out a little survey: when he asked people who were in hospital for overdoses what drugs they had taken, 100% were linked to chemsex, defined as the combination of an *upper* (stimulant) – generally crystal meth –, and a *downer* – first ketamine but since it was prohibited, GHB – and a psychedelic, like ecstasy.

Our role at Reshape is to help people build projects and partnerships for sexual health, mental wellbeing, social equity and justice. We help people work together, we believe in solidarity, we believe in trying to make intersectional connections. We're networkers.

When we launched the first Chemsex Forum in 2016[3], our goal was to welcome people who engaged in chemsex, healthcare providers, people from the community, researchers and service people. Not only gay men. Trans people were included from the very beginning.

Values to promote

During the second Chemsex Forum, in Berlin, we identified what we called the "problematic chemsex journey", to understand when it was possible to intervene. This is the journey: Somebody arrives, is lonely and wants to get involved in the community. They go out, they try to make friends, they use apps that introduce them to drugs, they

[1] https://doi.org/10.1016/S0140-6736(13)60032-X

[2] https://reshapeorg.com/

[3] https://reshapeorg.com/chemsexforum/

Ben Collins, © CD

take drugs, they feel incredibly happy. They make a lot of friends. Those friendship ties fail and then they're back in the same place, being very depressed and lonely. This was already very common. I think we really need to reconsider our representations. At the forum in Berlin, we observed many people felt like they were in an impossible situation: criticised for barebacking, criticised if they didn't; criticised for slamming, and criticised if they chose not to; criticised if they were on PrEP and criticised if they weren't.

How is it that as a community we're taking drugs that are getting more and more dirty and more and more threatening to us? These are real existential questions we're facing. Whether they feel desperate or not, people are taking more and more risks and trying to do several things at once. They're working as much as they can and as fast as they can, and also have lots of partners. I think this makes "community stress" a relevant concept: marginalised people have specific stress. People living with HIV are stressed, because of the anxiety, stigma and discrimination they have to face.

If you do a Foucault kind of analysis of what's going on, you see that we've created these structures in our communities that in fact operate quite like any other cultural institution in a capitalist situation: they start cutting ties with people and serving their own interests, over the needs of the community.

To get out of this dead end, we have tried to define essential subjects and values for the Chemsex Forum we will hold on July 20th in Munich, before the international Aids conference.

Solidarity is fundamental. We want to encourage real collaboration within the community, to get off individual beaten tracks, particularly as far as health and HIV are concerned.

Then we have to acknowledge a number of people are attracted to intense drugs, for pleasure or escape and this use, in the marginalizing context gays live in, impacts their health.

Lastly, we need to go back to doing and demanding prevention. Everything's about PrEP today. Nothing about U = U for instance [the fact a person living with HIV, taking treatment, with an undetectable viral load can't transmit HIV]. It's as if the entire construct of combination prevention has been replaced by PrEP. Concerning chemsex too, harm reduction isn't enough. We should be doing prevention, especially for young people, because we're seeing too much sexual initiation through chemsex for young people aged 14 to 17.

A broader perspective

Today we need to work with a broader definition of chemsex. We need to be more inclusive. On our Chemsex Forum Platform[4], a lot of people tell us that sexualised substance use, particularly by sex workers and trans people, is spreading. Certain sex workers who have gay customers engage in chemsex because that is what they are asked to provide.

The notion of integrated approach has to become better known and more popular: key populations are more diverse than we have chosen to see so far, and their specificities must be taken into account for mental healthcare, harm reduction, sexual health and drug addiction. Taking into account the cultural aspects will allow us to create integrated and relevant responses for key populations.

These forums must also allow us to strengthen our collective response to chemsex and particularly on an international level, by getting international bodies, governments, funders, and healthcare providers involved. The WHO will present their suggestions for guidelines regarding chemsex during the forum. "

[4] *Chemsex Forum Platform on groups.io, https://chemsex.groups.io/g/main/topics*

The stuartian legacy of 56 Dean Street

Christelle Destombes

56 Dean Street is a sexual health clinic that belongs to the Chelsea and Westminster NHS Foundation Trust. In Soho, the heart of London's gay community, the clinic welcomes clients of all ages and genders with no appointment, and provides support tailored to chemsexers' needs. This is where David Stuart developed the bases of a response that set a precedent for many European Checkpoints.

Dean Street's building in SoHo

It is a clinic that does not look like a clinic. At 56 Dean Street, in the heart of Soho, the several-story building looks like a hotel, with large leather seats in the waiting rooms and psychedelic wallpaper.

The 56 Dean Street sexual health clinic offers comprehensive sexual health evaluation and treatment, contraception services, and care and follow-up for people living with HIV or hepatitis B or C. One of the clinic's most important aspects is that it is multi-disciplinary – with doctors, nurses and medical auxiliaries – and non judgemental. The team offers personalised psychological support in individual sessions with health advisors.

On its website, 56 Dean Street claims to "have a deep understanding of factors around LGBTQI+ lifestyle, psycho-sexual issues, the impact of wider society, discrimination and drug taking". A truly unique approach that was partly tailored by David Stuart, who started out as a volunteer for Antidote (cf. pp 52) then joined the staff at Dean St. He worked there for eight years, in charge of the addictions service, before his sudden death in 2022, aged 56.

David Stuart didn't just coin the word chemsex[1]. He also designed methods to support chemsexers. He considered chemsex to be an eminently gay practice, linked to gay culture, social attitudes, homophobia, AIDS stigma, and also the impact of dating apps and gay social habits. A drug user himself for a decade, he shared this experience on his website: "I found myself sober'ish, with a criminal record for drug dealing, a considerable accumulation of traumas, and with a fire in my belly that drove me to raise awareness about chemsex."

As well as contributing to studies, he created "Dean Street Wellbeing", with personalised online support, harm reduction advice and information about drugs and sexual health. He produced videos to induce behaviour change (to manage craving, advice to cut down on using, sober sex, reduced risks) and shared recreational / social alternatives in London to chems saunas and clubs[2]. David Stuart launched the Let's Talk about gay sex and drugs open mic evenings that were then put into place in Amsterdam and Berlin… He is unanimously recognized as having been a tireless activist and having contributed to many international publications, to protect his community[3].

Today, Dean Street continues with this task. Whoever needs help with chemsex can make an appointment for an initial twenty-minute evaluation with one of the Dean Street experts. They are given access to a safe and confidential space in which they can discuss:

– harm reduction
– cutting down on use
– stopping
– preventing relapses.

[1] *David Stuart (2019) "Chemsex: Origins of the Word, a History of the Phenomenon and a Respect to the Culture", Drugs and Alcohol Today, Vol. 19 Issue: 1, pp.3-10.*

[2] *Certain videos can be watched on David Stuart's YouTube channel: https://www.youtube.com/@DavidStuartChemsex*

[3] *For instance, the following harm reduction brochure is available on the International Drug Policy Consortium (IDPC) website: https://idpc.net/publications/2019/01/chemsex-first-aid*

56 Dean Street
Kind and compassionate service

Interview by Louise Bartlett for *Swaps*

Aaron Chady started off as a teacher, then worked as a youth worker for a sexual health service. He trained in HIV testing and sexual health outreach, volunteered at David Stuart's clinic, and now works as a health advisor at 56 Dean Street.

What is the chemsex situation like today, in London and the UK?

It is a rapidly spreading problem, spanning geographical boundaries. People can find chemsex drugs on dating apps, on the dark web. They're accessible everywhere, including in rural areas. People who weren't exposed before are being exposed now. Chemsexers don't fit in the classic drug addict demographic profile, and the little support available for them is mostly in drug services funded by local authorities. A referral to a drug support service will be based on which borough of London the person lives in or, outside of London, their town or local authority. This means there are discrepancies between different parts of the country and access to service. People will travel far and wide to access a culturally competent service that has earned their trust. But there should be appropriate help for them closer to home, with cross-coordinated drug, sexual and mental health services.

Who comes to the Dean Street clinic?

About 70% of our patients are from the LGBTQ community. The other 30% are half straight women and half straight men. We have specific services for chemsex, because so many of our patients are concerned.

Doctors and nurses also refer to us: people who are in danger (homeless or abused), which can mean they do not engage well with their sexual health; people who have passed out on G, which is a big harm trigger; people having trouble with crystal meth, or who report having had non-consensual sex; asylum seekers. Being HIV or HCV positive can require more help with harm minimization, and adjusting to the diagnosis if it is new. We try to prevent further harm, and will do partner notification face to face or over the phone, following the "BASH"[1] guidelines.

We have specific outreach services for the trans and non-binary community, but since we are open access, anyone can come.

Do you know how many patients are doing chemsex?

The data we have at the clinic doesn't easily enable us to monitor that. All of our monitoring is generally done around tariffs, for how many chlamydia or gonorrhoea infections we treat. That's what we get paid for: the diagnosis and treatment of STIs. Likewise, you probably wouldn't have information in a drug service about how many patients are living with HIV or take PrEP. Not having all the information tied together is part of the problem. At the clinic, I see chemsex largely in the LGBT community. According to a recent audit we did, 86% percent of chemsexers are gay men, some are trans and non-binary, a few are straight. My estimate would be one in six of our patients are into chemsex, and about 20% of gay men will have tried a chemsex drug in the past year. Most people doing chems are over the age of 30. A small group of people are under 25. A lot of gay and trans people under 30 tend to get into chemsex because of sex work, where chems are very common. Crystal meth and other chems can calm gender dysphoria anxieties. For trans people who do sex work to fund what is a very expensive medical process, the cycle can be very difficult to get out of.

What services does 56 Dean street provide for chemsexers?

As a sexual health provider, we are open access and have some flexibility to work on these different threads. We used to be drop in, now we do liaison, which means we offer appointments to people who disclose chems use, which they do so readily at this clinic. David Stuart, who I worked with closely, set the ground for harm reduction, and kind compassionate service. We have developed lots of self-help tools, based on motivational interviewing, sexual wellbeing and safer practices. We respond to sexual health needs: prevention, PrEP, PEP, HIV medication and observance, Mpox, vaccination. Regarding HIV, chemsex can be problematic, because people will forget to take their treatment. I put together in-house training on harm minimization that everyone in this clinic should be able to deliver, which implies being confident in asking

[1] *British Association of Sexual Health and HIV.*

people about G-dosing, discussing how to reduce the risk of overdose and to stay safe.

Who at the clinic works with chemsexers?

The psychosexual therapy team addresses sexual problems, which can include compulsive sexual behaviour and chemsex. In response to the large number of referrals we receive, there are now nine health advisors, and one senior health advisor. We health advisors are prevention workers. All the doctors and nurses ask about chems in every consultation. They will focus on diagnosis and treatment, and refer to us people whose cases are more complex. Three of us are chems trained and have worked on drugs before, which is helpful. I used to work a lot with asylum seekers, others have worked in prisons, on domestic violence or social work. We can refer people between us, based on our specialisations, but we also learn from each other, to be able to provide equal care.

How do you proceed with patients?

We have a triage chat with the person who is referred to us. We establish rapport, reassure them, assess their situation and identify issues: what are they using, how often, how much, any recent escalation of their use, and define with them what their goals are and what kind of support they need. We discuss why they want to change things now, and work on that. We can't can offer a huge amount in terms of holistic support. If the appointments we offer aren't enough, on discharge they will have a care plan we set up with them. This can involve their GP, who we will write to with the patient's authorization, to get help with mental health for instance. We can also refer people to the Drug Club Clinic[2], or other organisations and groups.

Are there specificities to helping asylum seekers?

It's not uncommon to have a few sessions with them, because there will be a lot to cover around sexual well-being, getting them vaccinated, and started on PrEP, or meds if they're HIV positive, getting them adjusted to testing and practices in this country, keeping them away from things like chems, which I think they're particularly vulnerable to, sometimes through sex work, or because they're put into a center with people who mistreat them in their country, where it's stigmatized or even illegal to be gay or to be trans, and they just want to escape that. Chemsex is ubiquitous on dating apps now. A lot of asylum seekers are lonely and fire up apps to make friends. They're trying in earnest to find networks but not looking in the right places or they're just unlucky in meeting people who are using. It can become a real problem for them. We make sure they're engaged with legal support and attending at least one asylum seekers group, that they're socially doing something for themselves that will keep them away from the temptations of being overly reliant on apps or being drawn to things that may be overwhelming for them. Social integration is important and not just for asylum seekers. People who are not out or not very savvy at navigating the gay world may also need a bit of advice around how they might meet people and what's an appropriate boundary in the sex that they're having.

How do you address issues around consent?

As long as there have been chems, there have been consent issues - because people can easily get too high. With G, people can pass out and be completely unable to consent. G is liquid, it's often put into people's drinks without their knowing and can also be put in lube. We always ask "Are you safe? Is there anyone in your life who has made or is making you have sex you don't want?" David encouraged us to add a third question along the lines of: "Was there a time when you yourself, when under the influence, may have done something that you felt might have crossed a line for someone?" There are people who probably wouldn't do something non consensual in another setting, but have done it on chems. That can also be traumatising. He insisted on the need to be very compassionate about that as well, although it may be troubling to get a disclosure of perpetration.

How do you discuss chemsex with patients?

We ask very clear questions – what drugs are being used, and how, including injection – and provide incredibly clear information. We are honest about what problems can arise, to help people decide if it's important for them to make changes at this point in time, and, if they're going to do it, how they're going to do it. Patients can't be open with certain people in their life for fear of judgement, stigma or incomprehension. It isn't easy for anyone to talk about having a drug problem or a sex problem, let alone someone who may have both and maybe also mental health issues. People know that at the clinic they will meet someone who's competent enough to ask the right questions.

56 Dean Street,

Soho
W1D 6AQ
https://www.dean.st/
https://www.dean.st/chemsex

[2] *https://www.clubdrugclinic.cnwl.nhs.uk/ for people living in Hammersmith & Fulham, Kensington & Chelsea, Westminster*

Paris, a committed City Council

Christelle Destombes

The Paris City Council promotes the development of a common culture on chemsex and supports the networking of the professionals and different actors involved. Slowly but surely.

Since 2019, the Paris City Council has taken up the issue of chemsex. Anne Souyris, a member of the Green Party (EELV) and at that time Deputy Mayor for Health, tabled a green motion calling for an assessment of the chemsex phenomenon and the development of a prevention strategy. Several organisations, including *Vers Paris sans sida* (Towards AIDS-free Paris) and the *Mission métropolitaine de prévention des conduites à risques* (MMPCR – Metropolitan Mission for the Prevention of Risky Behaviour) had begun working together before the Covid crisis, which unfortunately put the brakes on their work.

Anne Souyris and Jean-Luc Romero-Michel, Deputy Mayor in charge of Anti-Discrimination policies, presented a new resolution to the Paris City Council in March 2021 concerning the organisations working on the chemsex issue. In May 2021, the City Council called a meeting with the organisations in question to draw up an information and harm reduction plan for Paris.

With this in mind, the MMPCR drew up an initial inventory of existing resources and the needs identified by those working with the groups concerned. The report, published in the summer of 2021, paints a mixed picture: ragtag resources, partial responses provided by those working in the field, difficulties in accessing care, lack of information and training for healthcare professionals, firefighters and police officers, lack of information for the general public on the care available and lack of awareness of harm reduction policies[1], etc.

The aim is to promote the development of a common culture on chemsex and to facilitate networking for the professionals and players involved.

Two working groups co-chaired by the MMPCR and representatives from community organisations meet regularly to provide practical solutions. Among other initiatives, Paris organised three working days in June 2022, 2023 and 2024, bringing together professionals and organisations likely to meet chemsex users[2]. The city has published an online map listing the medical, harm reduction and support services available in the Paris region. It has also launched a publicity campaign:

[1] https://mmpcr.fr/app/uploads/2023/01/20220211_Chemsex_ETATDESLIEUX_VF.pdf

[2] https://mmpcr.fr/evenements/chemsex-comment-accompagner-publics/

Paris' campaign: Chemsex, where to talk about it?

"Chemsex où en parler" (Chemsex, where to talk about it[3]). Specific harm reduction tools, such as the "Roule ta paille" (Roll your straw) kit for chemsexers, were distributed to 1,500 healthcare professionals in 2023. On the front of the kit is a QR code leading to a "Where to talk about it" campaign, and on the back is a list of risk reduction tips.

Community health and harm and risk reduction actors as well as institutional partners (AP-HP, ARS, CPAM, University Hospital Group for Psychiatry and Neurosciences, Mildeca, Paris Law Courts, Police Prefecture, City of Paris) are members of the strategic committee for the prevention and reduction of risks associated with chemsex. "The aim is to promote the development of a common culture on chemsex and to facilitate networking for the professionals and players involved", says Mathilde Serot, who co-organised the second thematic day for professionals and wrote her thesis on the subject of "Pathways, practices and care for chemsex users in Paris and the Seine-St Denis region".

[3] *https://www.paris.fr/pages/chemsex-ou-en-parler-21306 and https://capgeo.sig.paris.fr/Apps/Chemsex/*

Jean-Luc Romero,
commitment and… frustration

The *Swaps* editorial team met Jean-Luc Romero in his office at Paris City Hall at the beginning of April. A tireless campaigner in the fight against AIDS, the first politician to disclose his HIV-positive status, the founder and chairman of *Élus locaux contre le sida* (Local Elected Officials Against AIDS), he has been committed to developing drug prevention since the loss of his husband, who died at a chemsex party in 2018. In his view, chemsex shares many similarities with the AIDS epidemic, especially in its early stages. The shame of those affected, the loneliness of their loved ones, families who are powerless… and the inaction of the public authorities.

Jean-Luc Romero, © Mairie de Paris

"My concern is that, as in the early days of HIV, community associations will be left to fend for themselves, with no dedicated resources. There's no public debate on chemsex. We need the government to implement the proposals in Amine Benyamina's 'Chemsex 2022' report, even if it's only the first, real, full-scale epidemiological study. It has been said that AIDS can also be cured through politics. However, there is no balanced approach to the issue of addictions, only repression."

Convinced that the only effective way forward is to provide increased support in care pathways, he deplores the limited steps taken and the silence on this question. "I've met the Minister of the Interior (Gérald Darmanin) several times now and I've asked the Police Prefecture to set up a 'Good Samaritan' system to enable people who call for help when someone is unwell at one of their parties to escape prosecution". The Paris City Fire Brigade, which is made up of military personnel, informs the police when it is called to deal with a chemsex-related problem (coma, G-Hole, etc.). Never one to let go, Jean-Luc Romero has asked Catherine Vautrin, Minister for Labour, Health and Solidarity, for a meeting to discuss chemsex. He says he has obtained an agreement from Gérald Darmanin to experiment with a police-users truce in the Île-de-France region and he is advocating his peers in the *Élus locaux contre le sida* group to share the information tools developed in Paris.

"We are still waiting for a national plan to be launched and for networks of professionals to be structured to support users, as recommended in the Benyamina report", he adds. In the meantime, like other European cities, Paris is coming up with solutions to meet the needs of poorly identified chemsex users, who suffer from multiple and repeated stigmas. "Chemsex reveals the still difficult situation of the LGBT community, the internalised homophobia, the problems of HIV-positive people, the taboo, the shame of chemsexers, a reality that needs to be taken into account…"

“Le Parc” Quality support for chemsexers

Interview by Christelle Destombes and Didier Jayle

At 51 Boulevard Beaumarchais, in the heart of Paris, Aides, a community organisation, has designed a warm and welcoming sexual health centre, the Beaumarchais Spot, well away from traditional medical healthcare contexts.

This is not a design store, despite its large glass storefront window, complete with a transparent printed logo. For chemsexers, the Spot Beaumarchais provides information, specific risk reduction equipment (roll-your-own snorting straws, pipettes, dosers, syringes) and collective self-support encounters: Tuesdays at 7:30 p.m., the “Chemsex Chillout” evenings give users an opportunity to discuss using psychoactive substances in sexual contexts and the possible difficulties this can cause. All in a peer-to-peer self-support format.

On the second Tuesday of each month, users can also have their products analysed with partner organisation Analyse Ton Prod IDF. Products can be dropped off before the evenings in question. The aim is to be better informed about the products being used, so as to better implement risk reduction strategies.

In addition to the Chillout evenings, the Spot offers individual interviews to talk about sexuality, product consumption and PrEP, as well as the possibility for chemsexers to meet up with health professionals (a sophrologist, a sex therapist, an infectious disease specialist and an addictologist) and get referrals to partner organisations and addiction services for residential care and/or consultations.

The team at Aides’ Spot Beaumarchais centre runs a “mental health chemsex addiction” project in partnership with the 190 sexual health centre[1]. In addition to both structures’ other activities, services for chemsexers include referrals after an initial addiction consultation to an addictology follow-up (either at the 190 or with an external psychologist, doctor or counsellor); specific harm reduction consultations and/or a Reinforced Community Support Program (in French *“Parcours d’accompagnement renforcé communautaire”*, or Parc).

Thibaut Jedrzejewski, © le 190

This program was created for chemsexers followed at the Spot by a doctor or a counsellor, and who need additional support. “Parc” offers multidisciplinary consultations and workshops (adapted sports, visual arts, writing, hypnosis, etc.) to limit addiction symptoms and (re)learn to connect without chemsex or dating apps. Thibaut Jedrzejewski, the director of the 190, details the aims of this program.

What is the Parc program?

Thibaut Jedrzejewski: Parc is a three-month program that can be renewed for an extra three months. So maximum six months. We started in the fall of 2021 and have accompanied 25 people since then. We try to include ten people per session. About half of them follow the program twice. Parc provides more flexible, qualitative

[1] *190 is a CeGIDD (“Centre gratuit d’information, de dépistage et de diagnostic”), a centre for free information, screening and diagnosis of HIV and STIs.*

The building in Paris, © Aides

Le Spot flyer

support than what is on offer at the hospital. Nothing is mandatory. Regular appointments are available at least once a week: with peer counsellors, nurses, psychologists and sexologists. We also organise workshops: adapted sports, theatre, visual arts, group hypnosis, writing… according to people's needs and means. There are two support groups per month: one to review the program, group dynamics, people's expectations and the workshops, and another, the "café psy", run by psychologists, to talk freely about any subject.

We have two specific consultations: auriculotherapy, sometimes employing the NADA protocol (National Acupuncture Detoxification Association), that certain care support and addiction prevention centres use for craving due to stimulant drugs. The other is foot reflexology, aimed at helping people for whom touching and being touched is difficult, to reconnect with their bodies. These two consultations receive very positive feedback. People can work on their relationship to their body, with trained care professionals. The chemsexers realise they haven't been touched for ages. Taking time to perceive physical feelings that aren't very directly sexual opens the door to sexuality without substance use.

Is sexuality without substances the goal of this program?

TJ: Each person sets their own goal. To join the program, they have to want change - regarding drugs, the rhythm at which they use, their social lives, or to find a job… As far as addiction is concerned, the aim isn't to stop altogether, but to find a relationship with drugs that feels

Taking time to perceive physical feelings that aren't very directly sexual opens the door to sexuality without substance use.

better, that feels more serene… The chemsexers we see are often very isolated, desocialised: drug use can make this situation worse, or be the cause of it. The idea is to empower people, showing them that there are other ways to belong to a group, to meet people, ways other than direct sexual contact with no desire but in a state of sexual arousal, to connect with people differently. The workshops enable participants to feel pleasure differently, in other circumstances.

Who is the target audience for this program?

TJ: Chemsexers, based on the definition of chemsex as drug use in a sexual context specifically involving MSM, trans and non-binary people. They must feel they have a problem because of chemsex and want treatment. We do have exclusion criteria: we don't integrate people who could put the group in a difficult position, or vice versa. The goal is to form a group within which people can meet and connect. Our work focuses on these people's social, sexual and affective situations.

How did this idea come about?

TJ: We were overwhelmed by things happening at the 190: even with several of us working together around each of the patients, we rapidly felt limited in what we could achieve. Thomas l'Yavanc, an addiction doctor at the 190, followed the example of outpatient day hospitals, proposing workshops and almost daily presence for people experiencing difficulty. We worked for two years developing the project with the team at the Spot. It took us time to weave the project together, involving an Aides community support centre and a community health centre like the 190… specifically to manage to combine medical and non-medical community approaches, while these two poles generally have little experience working together.

What is missing from your program?

TJ: Funding! We operate like a health centre, billing public health insurance and private insurance companies for services. We have received partial funding from the Regional Health Agency addiction fund and for the time being the NGO Aides covers all remaining expenses. But this program is expensive, and we need to find other sources of funding, to develop additional, more permanent workshops… The main thing that's missing is a sufficient number of links with partner professionals who understand chemsex, its context and the issues it raises. Care providers need to address matters related to sexology and the LGBTQI+ community: coming out, and the way people live their sexual orientation, can play a crucial role in chemsex complications. Chemsex and chemsex complications are often mixed up, as are addiction and its complications. Finding sensitive caregivers who offer comprehensive care is complicated. What's also missing is prevention: detecting problems before they arise. We could do screening and prevention during HIV or PrEP consultations. But taking care of people with complications requires large, multidisciplinary programs, with regular, time-consuming and difficult consultations for caregivers. And there needs to be a community response: places to recreate connections other than through sexual excitement, places that leave space for desire.

Harm Reduction Tools

Tim Madesclaire, a peer counsellor at Spot Beaumarchais, has a good understanding of the issues related to chemsex. He worked on the Apaches study (see *Swaps* nº 92-93) and contributes observations and testimonies for the OFDT, a French agency monitoring drug use and addictions, and their Trends reports on gay party scenes and others associated with chemsex. He is currently developing, in the ARPA project, a self-assessment tool for "happy chemsexers", people who don't necessarily have problems with chemsex. "We are creating a decisional balance check sheet, inspired by the one used at the Checkpoint in Berlin" (https://checkpoint-bln.de/en/chemsex-check/), he explains. "It allows people to define boundaries between what they can do and what they no longer want to do in connection with chemsex. People who don't have problems with chemsex don't manage to finish the chart… We might well use it during consultations, and also share it online and in bars."

The Spot Beaumarchais also offers the possibility to test substances with the support from the Île-de-France region Trends program. These analyses show that since 3-MMC was classified as a narcotic in the Netherlands in September 2021, 3-MMC appears to be increasingly replaced by 3-CMC or other cathinones with similar effects (3-MMA, 2-MMC, 4-MMC, DMBDP…). Even if this substitution is sometimes unknown to the consumers who purchased the product and the dealers sourcing it online…

The Checkpoint, a multidisciplinary offer for chemsexers

Christelle Destombes

In the *Sentier* neighbourhood in the centre of Paris, the Checkpoint (attached to NGOs ARCAT and Groupe SOS) offers a welcoming and bright space to all LGBTQIA+ people and sex workers. As a community-oriented sexual health centre including a unit for free screening and diagnosis, it offers rapid PrEP initiation, prevention tools, care and appointments. All free of charge.

Large windows overlook a quiet little square. Everything is transparent, inclusive and caring. At the Paris Checkpoint, chemsexers can consult an addiction doctor, a nurse specialised in harm reduction and/or a health mediator, whatever their motivation: assessing, controlling, reducing, and/or stopping drug use. Maxime Odoul, the coordinating nurse, and Franck Aldon, a nurse from Safe[1] who offers specialised consultations for injection-related wounds and complications on Wednesdays, present the Checkpoint to *Swaps*.

A customised offer

The Checkpoint developed a specific response to chemsex issues in 2021. Of the 11,000 clients, 25 to 30% used psychoactive substances, and nearly 500 were identified as chemsexers. The initial project was to offer one addiction consultation service and one for sexology. Both were soon overwhelmed by demand. A multidisciplinary healthcare circuit was developed as part of the 2021-2024 sexual health plan "focussing on sexology, mental health, and addiction, which is generally the entry point", according to Maxime Odoul. "We designed the offer for MSM, who were coming with serious complications: financial insecurity, mental health disorders, anxiety and depression disorders. To be able to speak freely without fearing double stigma (substance use as well as being gay, engaging in rough or potentially risky practices), people need safe, community-run spaces."

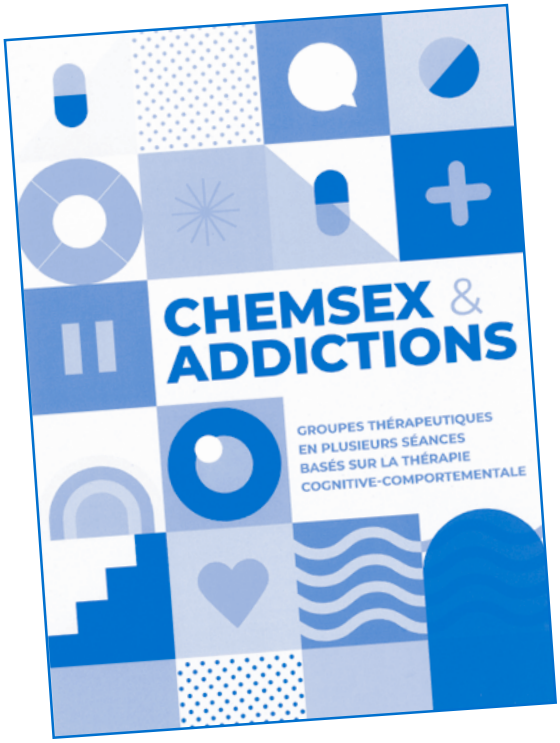
"The first contact is often for screening", says Maxime. "We are a sexual health centre and, for chemsexers, screening is an issue… We present the care the Checkpoint provides: the various spaces and consultations – what the sexologist does, what the addiction doctor does, what the harm reduction nurse does. Requests are primarily to address consumption issues, long before talking about sexology, mental health, or psychiatric and psychological assessment. We talk about drugs, we ask questions aimed at helping people reflect upon and auto-assess their drug use: is it to have relations? Have there been changes in their social or professional life, in relationships? Then, we ask if they want to meet any particular staff person."

A network of partners

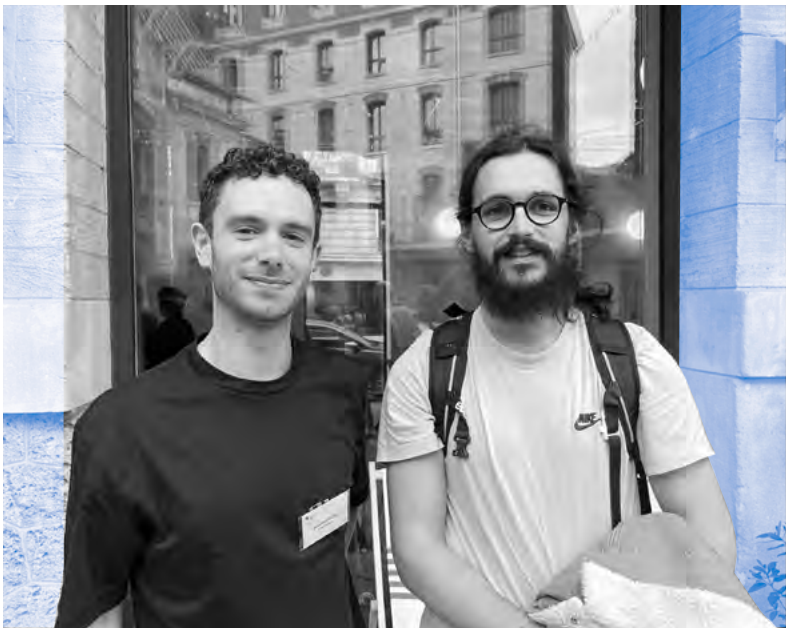
The Checkpoint works in partnership with many organisations, to which it can refer people according to their needs. People living with HIV or HCV, or who want to stop using drugs, are referred to hospitals, especially those who have already experienced good results quitting cathinone and GHB. Those needing psychiatric care may be referred to specialised consultations offering cognitive-behavioural therapies for chemsexers. Certain addiction and/or mental health care structures offer cognitive-behavioural therapies for chemsexers. In total, the Checkpoint has around fifteen different partner organisations offering psychotherapy.

Self-support groups are co-facilitated every Tuesday at a centre called the Spot Beaumarchais (cf. pp 63), by a counsellor from their team and a mediator from the Checkpoint. Participants can speak freely about their experience. The same facilitators hold drop-in sessions on Saturdays, at the Checkpoint. "It's an entry point, even on weekends, where people can come and meet someone,

[1] *Safe is a harm reduction organisation: https://www.safe.asso.fr/*



Leaflet for the therapeutic groups proposed by the Checkpoint and its partners



Maxime Odoul and Franck Aldon, © CD

where they can get harm reduction material", explains Maxime. The Checkpoint also aims to raise awareness about chemsex among professionals. "Certain structures for drug users were receiving chemsexers without knowing where to direct them, or how to talk about sex or sexuality."

Slamming

When injected, cathinones pose an additional problem. This led to the Checkpoint accepting Safe's offer of an advanced nursing consultation. "There is no training on managing injection-related wounds and complications, there's nothing on these questions in the university diplomas", points out Franck Aldon. "Depending on the substances, there may be specific types of wounds, especially with cathinones, which are very corrosive." Safe being known for providing harm reduction material, Franck estimates that among the 600 people who consult there, about one in four are chemsexers, of whom 90% are injectors.

To be able to speak freely without fearing double stigma (substance use as well as being gay, engaging in rough or potentially risky practices), people need safe, community-run spaces.

Using all formats to respond to users – in person, by email, WhatsApp, telephone – Safe makes sure everyone can access care, guidance and advice. "People can come and access care directly. The aim is to relieve hospital emergency departments and to teach users how to analyse and manage complications themselves." Injections being frequent during chemsex sessions which can last up to 72 hours, a considerable number of needles need to be distributed. "One needle = one attempt to inject. And I have only met one user who succeeded each injection first time around… I recommend syringes with detachable needles and with a number of disposable needles adapted to a person's needs and practices, to reduce the risk of complications (burns, inflammation, abscesses, skin lesions…)."

The Checkpoint bills consultations for people with social security rights (*Sécurité Sociale* or *Aide Médicale de l'État*). It also uses HIV and STI Screening Service funds as well as receiving support from the Regional Health Agency. "To meet people's needs and increase availability, all positions should be full-time", says Maxime. "Networking with other structures is also essential." The Checkpoint is a pilot site for the ARPA project (cf. pp 69) and belongs to the Chemsex network, created in 2015 by the *190* sexual health centre.

The Checkpoint

40 people employed, 20 full time
5-6 deal with chemsexers
Drop-in with or without appointment
on the second and fourth Saturday
accompagnement.chemsex@lekiosque.org

SAFE

Nurse consultation by appointment
infirmier@safe.asso.fr

Chemspause, self-support for those who want to stop

Christelle Destombes

Jean-Patrick has set up Chemspause, a community self-support group for chemsexers who want to stop or pause their drug use. The group is visible on social networks (Instagram and Twitter), but exists mainly on Telegram, which is considered preferable to WhatsApp in terms of confidentiality. "It's much better than WhatsApp", says Jean-Patrick. "You don't need a phone number to sign up, all you need is a pseudonym, and you can't take screenshots on Telegram".

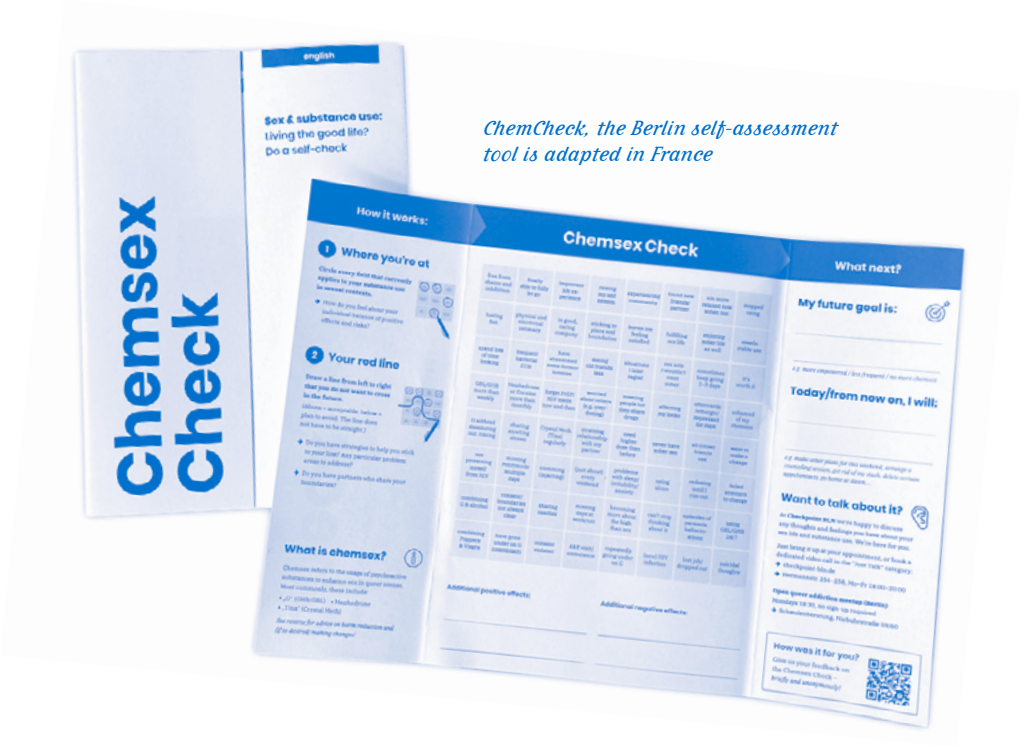
Almost a year after its creation, the group today has some 200 members. "There are people from all over the place: from Paris, Nice, Montpellier and all over France, as well as a few Belgians and Canadians. It's a group of people who want to stop chemsex or who want to cut down, and this community shares advice, contacts and support. It's about helping each other as a community, because sometimes we feel really alone".

Jean-Patrick created this group after a week of chemsex: "I was really unwell and I thought of someone in the same state as me who wouldn't have access to the Spot, for example, who lived far from any facilities…". The group, created for and on social networks as a reflection of the applications that encourage chemsex, can move up into the real world. "We meet up and organise things at weekends, go for walks, go to museums, and avoid thinking too much about chems. During the Pride weekend, around ten of us met up in Montpellier".

Open 24/7 and accessible from anywhere, this self-support group gives new meaning to the word community. "I didn't live through the 1980s, but in the AIDS years, it was the users who started to help each other, to take responsibility for themselves. I have the impression that with chemsex, it's a bit the same. With the group, people aren't alone. And taking care of the group is good for me too, because I'm still trying to abstain".

A number of moderators help Jean-Patrick manage the group and keep an eye on things. They validate new members who accept a "charter". Dealers and malicious third parties are not welcome. Jean-Patrick hopes that the authorities will finally take action in the face of this "growing phenomenon, which is doing a lot of damage".

https://t.me/chems_pause
https://www.instagram.com/chemspause



ChemCheck, the Berlin self-assessment tool is adapted in France

Arpa chemsex

Arpa (*Accompagnement en réseau pluridisciplinaire amélioré* – Enhanced Multidisciplinary Support Network), financed for three years by the *Fonds de lutte contre les addictions* (Addictions Action Fund), aims to "improve multidisciplinary sexual prevention and harm reduction services for chemsex users". The aim is to bring together a prevention service, a harm reduction or addiction treatment service and a community structure.

Several pilot sites have developed responses adapted to their local areas: in Paris, there has been an overhaul of support discussion groups, with the creation of a Checkpoint office run jointly with Spot. A self-assessment questionnaire is currently being finalised. Inspired by the questionnaire developed by Checkpoint in Berlin (see picture), it enables users to understand their practices and the boundaries they do not want to cross, and to engage in discussion with professionals. In Aix-Marseille, it is the occupational activity component (sailing, yoga, writing, breathing, etc.) that has been developed to offer alternatives to chemsex and rebuild social links.

In Bordeaux, hospital emergency teams have been trained at the request of the head of the department, and prevention and harm reduction videos on GHB are being produced, along with a drugs and sex harm reduction kit that GPs can give to their patients. In Lyon, a chemsex-health weekend was organised, with occupational activities, discussion groups and brainstorming sessions, etc.

All these initiatives will be compiled in a support guide that the Addiction Federation intends to finalise in 2024, based on three pillars: sexual health, drug harm reduction and referral to care and self-support. Targeting addiction, mental health and other professionals, the guide will include contributions from experts (including, for the infectious diseases section, the editor-in-chief of *Swaps*, Gilles Pialoux).

The evaluation of the project, which is currently underway, shows that the objective of creating partnerships between addiction and community structures is well on the way to being achieved. For Jonathan Rayneau, head of sexuality/chemsex projects at Addiction Federation, "networking is essential in supporting chemsex users. Chemsex requires a multi-faceted field of support, but when a chemsex user knocks on a door, whether it's an association, an addict or any other contact, he or she doesn't care who's in front of them. They just want to feel better with what they're doing". - CD

Lake, Sex & Drugs
Chemsex in Switzerland

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For decades, Switzerland has taken a pragmatic approach to substance use and sexually transmitted infections, particularly HIV. Today, it is adapting the measures it implements so that it can respond appropriately to the issues associated with the intersection of sexuality and substance use like chemsex, taking into account specific local and community characteristics.

Diverse realities

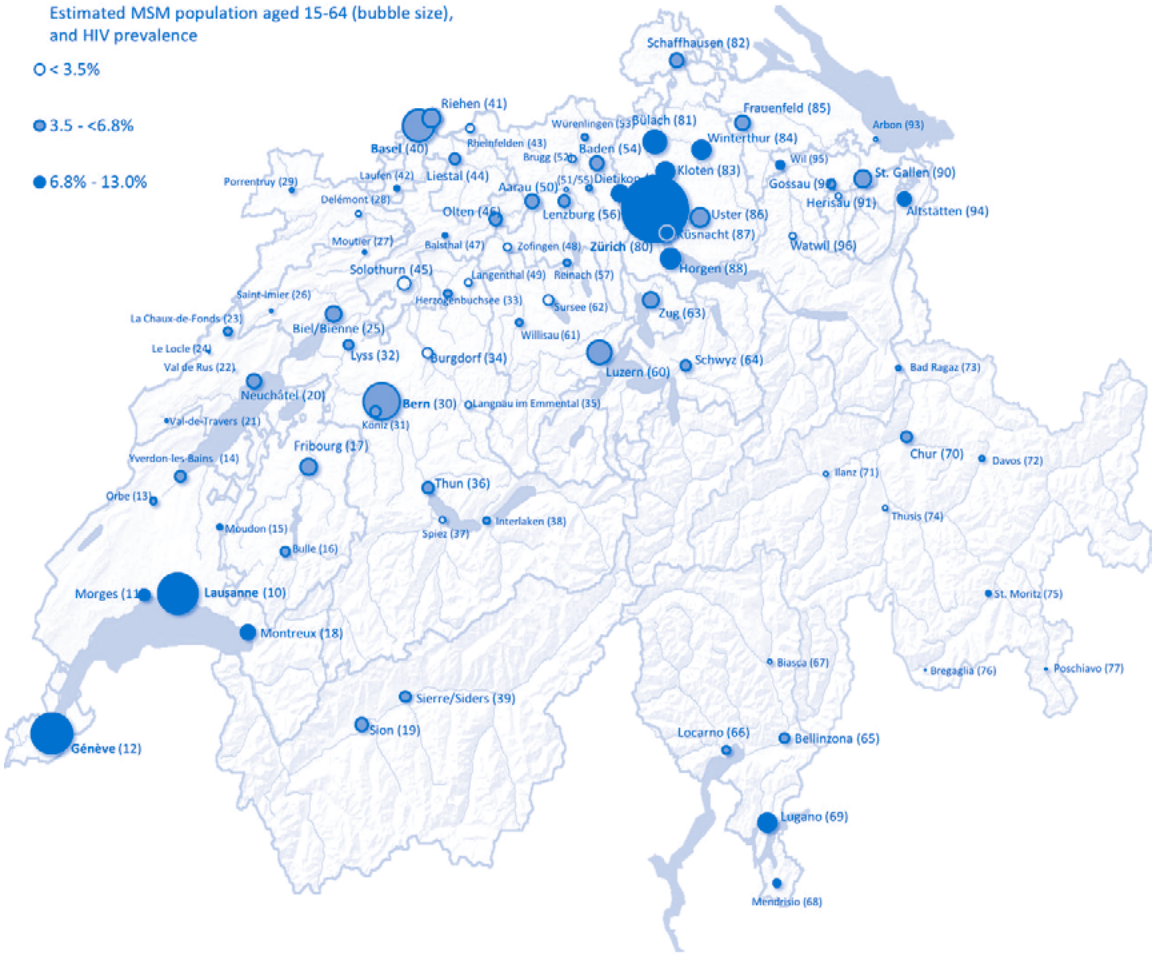
Despite what its size might suggest, Switzerland is a country with a wide variety of realities, partly due to cultural issues linked to different linguistic influences. For example, the realities of the gay community, including substance use and chemsex, are not the same in Zurich as they are in Berne and Basel. Nor are they the same in these German-speaking cities as in the French-speaking cities of Geneva and Lausanne, or in rural areas. For example, while cathinones seem to be present in French-speaking Switzerland under the influence of France, they seem to be less so in German-speaking Switzerland. Particularly in Zurich, where methamphetamine seems to be more prevalent than in the French-speaking part of the country.

Furthermore, the Swiss population, and the gay and queer community in particular, is extremely mobile. For an evening out, a weekend or a holiday, people move from one region to another or leave Switzerland for a major European city or another community tourist destination (e.g., the Gay Tour, Pride events, cruises, etc.). This mobility exposes "travellers" to other community cultures in terms of sexuality and/or consumption, but also health. This is why HIV PrEP appeared in Switzerland several years before it was officially authorised, and why DoxyPEP is now making its appearance. It is also a factor that can explain the differences in the products consumed, as well as modes of consumption and risk and harm reduction.

Population surveys of men who have sex with men have been carried out in Switzerland since 1987. Questions about alcohol and/or other substance use have always been asked, and questions about chemsex have been added to the surveys since 2010. The results show that substance use has always existed within the gay community and date the appearance of certain products (e.g. cathinones in the 2010s) or show the increase in reported use of other products (GHB/GBL, ketamine, methamphetamine…), suggesting a potential increase in the practice of chemsex. However, while the practice of chemsex is not negligible, it seems to remain a minority issue and, with regard to slam, rather marginal. This was at least the case in 2017, when the most recent data on the subject was published for Switzerland.

In 2017, data analysis from the Swiss HIV cohort study showed that substance use associated with chemsex among cisgender MSM living with HIV was more common for those receiving treatment in Zurich than in other cities.

Fig. HIV prevalence in men who have sex with men in Switzerland



In Switzerland's "gay capital", the number of such patients has risen sharply over the past ten years. GHB/GBL is the most frequently reported drug (1% in 2007 and 3.4% in 2017), followed by methamphetamine (0.2% in 2007 and 2.4% in 2017), ketamine (0.1% in 2007 and 0.7% in 2017) and mephedrone (0.0% in 2007 and 0.2% in 2017). Methamphetamine use is more common among cisgender MSM living with HIV in Zurich (4.5%) and the other large German-speaking cities (around 3% in Berne, Basel and St. Gallen, close to the national average of 3.4%) than in the large French-speaking cities (1.7% in Geneva and Lausanne).

GHB/GBL use was also more common among users consulting in Zurich (9.9%) and Geneva (5.9%) than in the other cities.

Although injecting drug use does exist, particularly in certain sub-communities, with some people discovering that they are living with hepatitis C[1] we are a long way from the feared "epidemic of slam and related hepatitis". Nevertheless, people who inject drugs do need to have access to sterile equipment and to screening and treatment for HIV and viral hepatitis.

Taking antiretrovirals as a preventive or therapeutic measure now makes it possible to prevent HIV transmission and, with regular treatment, missing a dose or two will have no impact on this protection. Among people living with HIV or taking HIV PrEP, there is an over-representation of people having sex under the influence of substances, particularly those practising chemsex[2].

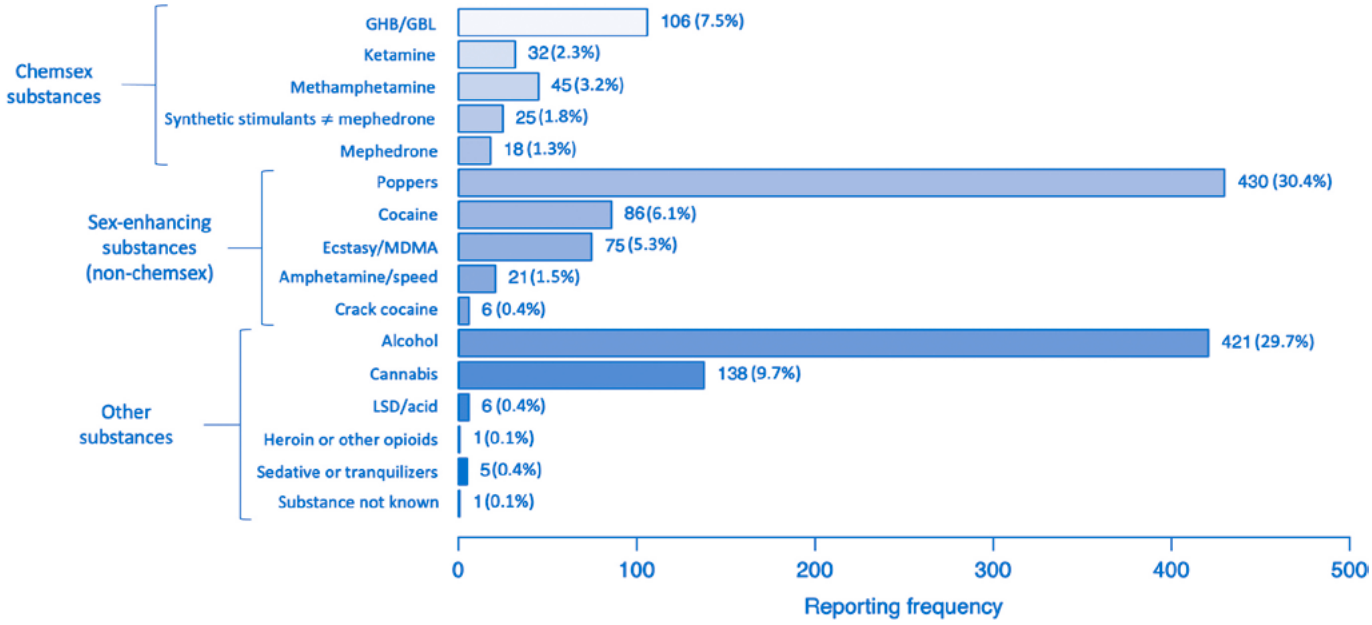
This suggests that these HIV prevention strategies are widely adopted by this population group. However, not everyone seems to be using them yet, particularly because of systemic problems with regard to access.

On the other hand, little data is available on (potential) intoxications, interactions, bad reactions, overdoses and other incidents involving the products mainly used in sexual contexts. Nor is there any information on requests to health and support services for problems related to chemsex or, more broadly, sexualised drug use. In these areas, knowledge is based on "critical clinical cases" and the proposed responses on medical measures. Much of the reality of sexualised drug use, particularly chemsex, remains largely unknown, as do the risk and harm reduction strategies developed by the users themselves.

[1] *Agosti-Gonzalez, R., Falcato, L., Grischott, T., Senn, O., & Bruggmann, P. (2023). Hepatitis C antibody test frequencies and positive rates in Switzerland from 2007 to 2017: a retrospective longitudinal study. Swiss Medical Weekly, 153(6), 40085. https://doi.org/10.57187/smw.2023.40085*

[2] *Hovaguimian, F., Martin, E., Reinacher, M., Rasi, M., Schmidt, A. J., Bernasconi, E., Boffi El Amari, E., Braun, D. L., Calmy, A., Darling, K., Christinet, V., Depmeier, C., Hauser, C., Läuchli, S., Notter, J., Stoeckle, M., Surial, B., Vernazza, P., Bruggmann, P., Tarr, P.... Hampel, B. (2022). Participation, retention and uptake in a multicentre pre-exposure prophylaxis cohort using online, smartphone-compatible data collection [SwissPrEPared]. HIV medicine, 23(2), 146-158. https://doi.org/10.1111/hiv.13175*

Fig. Substances used before or during sexual intercourse in the last 3 months among 665 SwissPrEPared participants[2]



Coordination and national measures

At the national or regional level, the Confederation mandates various organisations in the field of substance use: Addiction Switzerland and Infodrog and/or the Swiss AIDS Federation (ASS) in the field of prevention of HIV, other STIs and viral hepatitis. These organisations are responsible for informing the general public and professional circles[3] through websites, printed material, campaigns and the coordination of activities throughout the country. The Federal Office of Public Health (OFSP/BAG) and the national umbrella organisations are also responsible for defining, monitoring and evaluating the framework for action.

To ensure that issues relating to drug use, sexual health and the intersection of the two are addressed more – or even systematically – in both areas of intervention, training courses have been set up for health professionals, particularly those working in sexual health care[4] or drug use/addiction[5]. For monitoring and evaluation purposes, *ad hoc* questions have been included in the anamnesis tools (e.g. BerDa[6] for screening centres and the questionnaire accompanying *drug checking* for drug users) as well as in population surveys.

As far as chemsex is concerned, information measures are mainly implemented as part of the Swiss AIDS Federation's DrGay project[7]. These are based on a tried and tested model:

Drugs - Information on substances: composition (including product analysis and alerts), desired and undesirable effects, interactions between substances and with medicines, consumption patterns and risk reduction strategies *(Safer use)*.

Set - Me and my consumption: encouraging people to consider their biopsychosocial state of health before consuming and to assess their relationship with their consumption and its impact on their health and other aspects of their lives (self-assessment questionnaire).

Setting - The context in which I consume: encouraging people to take into account the issues related to where the consumption takes place and the other people present, in order to anticipate the risks.

When necessary, people are directed to the *ad hoc* resources closest to them, in particular by setting up directories with specific filters for these issues on the various websites (aids.ch, drgay.ch, sante-sexuelle.ch, lovelife.ch and indexaddictions.ch):

Sexual health and reducing the risks and harm associated with HIV, other STIs and viral hepatitis[8]: community and/or information and prevention organisations; sexual health and vaccination and screening centres, providing PEP PrEP or therapeutic care.

Consumption and addiction[9]: information and prevention organisations, drug checking, supply and exchange of drug-use equipment (including online[10]), safe consumption rooms (ECS), opiate agonist treatments (OAT), counselling (including online[11]) and therapy consultations, peer support groups.

In some cases, specific services for MSM, and more specifically for chemsex, are provided by Checkpoints[12],

[3] *e.g. https://sexndrugs.ch*
[4] *www.aids.ch/academy*
[5] *https://grea.ch/evenements/sante-sexuelle-et-consommations-2024-11-05*
[6] *https://www.bag.admin.ch/bag/fr/home/krankheiten/krankheiten-im-ueberblick/sexuell-uebertragbare-infektionen/freiwillige-beratung-und-testung.html*
[7] *https://drgay.ch/drugs*
[8] *https://drgay.ch/fr/contacts*
[9] *https://indexaddictions.ch/*
[10] *https://shop.aids.ch/fr/2155Shop/Mat%C3%Agriel-d%27information/Consumption-of-substances?c=121&hffffid_1-100_2-155=on&hffid=Shop,%20Filter,%20FilterS*
[11] *http://www.safezone.ch*
[12] *https://mycheckpoint.ch/*

health services for gay men, bi men and other MSM; some propose specific services for trans people.

Local implementation

Since its creation in 1985, the Swiss AIDS Federation (ASS) and its members and/or partners, in particular community partners in the various cantons, have been responsible for the bulk of HIV prevention activities among gay and bi men, and other MSM. This targeted prevention based on a participatory community approach has taken the form of a national MSM programme since 1994. While national measures are coordinated by the ASS, local measures are implemented and mainly funded by the cantons.

The same applies to national programmes on drug use and addiction, where national measures are coordinated by umbrella organisations such as InfoDrog, but local measures are implemented by local bodies.

This multi-level organisation means that implementation varies from one canton or town to another, depending on local realities and varying legal, regulatory and funding frameworks, as well as different social and political cultures.

Furthermore, prevention strategies in Switzerland with regard to HIV and/or drug use have historically been developed "by and for the people concerned". This participatory, community-based approach has made it possible to define strategies that take account of the realities of people's lives, with the implementation of measures by peers promoting their deployment and impact. These existing prevention programmes have been able to incorporate the intersectional issues of sexualised drug use, or could serve as a basis for the development of specific projects.

Safer Use material made available as part of the Dr Gay Sex&Drugs project run by the Swiss AIDS Federation:
– Safer Sniffing.
– Safer Dosing.
– Safer Slamming.
https://shop.aids.ch/fr/

As GHB/GBL is one of the substances most commonly used at parties and/or for sexual purposes in the gay community, it was essential to provide a harm reduction tool. A bottle with a pipette allowing measurement to ½ ml, combined with a table summarising interactions. The use of an intake monitoring chart is also encouraged to reduce the risk of overdose.

Drug checking

Drug checking has existed in Switzerland since the late 1990s. In the largest towns and cities, it is now possible to test drugs anonymously and free of charge, either at a drop-in centre or at a stand at an event.

This drug checking service has several objectives:

To provide people with objective information about products so that they can decide whether or not to consume them. In practice, people often decide not to consume a product if the analysis reveals that it does not correspond to what was expected, or if it highlights a risk of intoxication or overdose.

Enabling people to talk to trained people about their drug use. Drug checking is generally the first point of contact between drug users and professionals in the field. Experience has shown that the interviews help to change behaviour towards the adoption of an effective harm reduction strategy (mode of consumption, management of consumption during a session and over time, etc.).

Enable local and national bodies to monitor products in circulation (in addition to analyses of wastewater[13] and legal seizures[14]) and issue alerts in the event of products that do not correspond to what is advertised, or products that are dangerous due to their composition or concentration.

Enabling local and national bodies to get in touch with people who are otherwise difficult to reach, and to monitor changes in consumption (products and modes) and in the people who use a given product in a given context – particularly sexualised[15] – in addition to data from population surveys[16]. Here again, this enables organisations to tailor their prevention strategies and messages to the target audiences.

For example, drug checking has made it possible to monitor changes in the quality of cocaine in circulation and to adapt messages to the increase in concentration levels.

In the field of chemsex, drug checking has confirmed the circulation of cathinones that do not correspond to the advertised product, and the gradual replacement of 3-MMC by 3-CMC, which has a different risk profile.

In total, around 4,000 analyses are carried out each year in Switzerland, of which around 500 are mobile. The number has risen sharply in recent years as a result of the increase in the number of sites and, above all, duty stations. But this method has its drawbacks, notably the fact that the product has to be destroyed (which limits acceptability), the skills required to implement it and the time needed to carry out the analysis and obtain certain results (sometimes several days), which limit the number and deployment.

[13] *https://www.dromedario.ch/data, https://www.emedda.europa.eu/publications/html/pods/waste-water-analysis_en*

[14] *https://www.bfs.admin.ch/bfs/fr/home/statistiques/criminalite-droit-penal/police/substances-stupefiantes.html*

[15] *https://www.infodrog.ch/fr/publications/publications-par-theme.html#nightlife*

[16] *https://www.bfs.admin.ch/bfs/fr/home/statistiques/sante/determinants/drogues-illicites.html*

Community outreach

Although HIV prevention for MSM was developed in collaboration with community organisations on the model of community-based outreach work (ORW), community spaces are no longer the same. There are fewer community and commercial spaces, and they are frequented by only a minority of MSM. Outdoor meeting places still exist, but are only frequented sporadically. This is why, as far as possible, interventions in the physical environment are complemented by their digital counterparts (social networks and dating apps).

While substance use continues to be observed in party venues and in specific sex zones, the majority takes place in private or privatised places. People wishing to practise chemsex now meet *via* dating and/or messaging applications. Reaching these individuals and groups has become more complicated.

However, working with the communities in question remains essential if health-related knowledge and skills are to be passed on and reinforced quickly and effectively, particularly among the most marginalised members of society. The issues surrounding substance abuse and the recent Mpox epidemic in northern countries bear this out. In addition, regular contact with communities enables us to monitor their varying developments, needs and expectations. It also enables us to discover strategies and tools that have been developed by the communities themselves and that could usefully be incorporated: the nature and quality of the products consumed within the group, the choice of consumption methods, initiation/education with a view to harm reduction, a table for monitoring consumption (e.g. GHB/GBL) if possible managed by a specific person, solidarity between participants in the event of an overdose or loss of judgement (prevention of accidents, sexual abuse and rape), etc.

Individual and group offers

Services for substance users, and more specifically for MSM who practise chemsex, can be categorised according to approach and format.

In some cases, this necessarily involves receiving the person for counselling, or support with regard to reducing risks and harm. In other cases, stopping drug use, sometimes sexual abstinence, is a prerequisite for support in recovery. These two approaches are complementary, as each can meet the needs and expectations of the individual.

Epidemiology

In EMIS 2017, amongst the cisgender MSM residing in Switzerland, the vast majority (79%) were recruited *via* certain sexual partner dating apps:
– 11.8% (357/3019) reported having had sexual intercourse at least once in the last 12 months under the influence of at least one stimulant substance to make sex more intense or last longer.
– 1.3% (39/3052) said they had injected a substance at least once in the last 12 months.
Among the 8,059 cisgender MSM who consulted Checkpoints and other sexual health centres between 23/11/2016 and 31/12/2017 (BerDa data), 8.2% reported having had at least one sexual intercourse under the influence of at least one substance associated with chemsex (GHB/GBL, ketamine, methamphetamine, mephedrone/cathinones) in the previous 12 months.
https://www.emis-project.eu/wp-content/uploads/2022/09/EMIS-2017_National-Report_CHf.pdf
and Axel J. Schmidt, 2nd European ChemSex Forum: Berlin, 22-24.03.2018

The NIRLab revolution

The School of Criminal Sciences at the University of Lausanne (UniL) has developed an innovative approach to analysing narcotics.
It is based on three tools:
– a portable device the size of a torch using a NIR (Near Infra Red) analytical technique,
– a proprietary IOS/Android/PC application that can run on a mobile phone, tablet or PC,
– data processing software based on machine learning algorithms connected to a database of over 5,000 drug seizures.
The software analyses the data transmitted via the application and returns the qualitative (narcotics and blending products) and quantitative (narcotics) results in three seconds.
These tools make it possible to identify and measure the presence of certain chemical molecules with a precision close to that of conventional laboratory analysis methods. In addition, the analysis can be carried out without having to destroy the product, and removes the need to handle the drug, which requires time and specialist skills.
The main limitation of the NIRLab is that it does not recognise unknown substances and does not always allow analyses in the same detail as can be done in laboratories. However, with the right protocols, this method could replace or complement current methods and allow extension to new areas, while reducing the associated costs. In addition, the database can continually be enriched with new specimens.
A pilot project has demonstrated the effectiveness and usefulness of the tool, but legal and institutional limits are still restricting wider deployment.
https://www.nirlab.com/drug-checking/

The offer can be collective or individual. In Zurich, information and discussion forums have been set up in community venues (*Checkpoint Zurich*, *Checkpoint im Gespräch*, *Let's talk about Sex & Drugs*, based on the model developed in Berlin). Attempts to open similar spaces have been made in other cities but have not been as successful. Chemsex peer groups have been set up by the Checkpoints in Vaud (Lausanne) and Geneva.
Several Checkpoints also offer specific individual support. These can be provided by members of the gay community with nursing training and experience in the field of drug use, or by mental health professionals specialised in addiction. But these specific services are still few and far between and are concentrated in the largest cities. In addition, or as a subsidiary measure, Checkpoints and other organisations active with regard to prevention are gradually setting up multidisciplinary networks: infectiology, sexual health and sexology, mental health and addictology, etc., in order to offer a wide range of services and comprehensive support. The challenge is to be able to find suitable local specialists on these issues at the intersection of sexuality (between men), consumption (of certain substances) and minority culture/identity (gay) and to ensure that people can access them, particularly financially.
The Swiss AIDS Federation regularly organises a chemsex roundtable to give professionals in its network an opportunity to discuss the realities of their work and the specific issues they are faced with. GREA's *Gender and Sexuality* platform also discusses issues relating to sexualised drug use, and in particular chemsex, as part of an exchange between professionals working in the drug use and addiction network.

Opportunities and difficulties encountered

The growing interest in chemsex has led to the (re) discovery of substance use in the gay community and

during sex between men. Far from an objective approach aimed at assessing the real risks and providing an appropriate response, we are witnessing an outbreak of moral panic fuelled by surveys/studies of questionable methodology and the use of data and other interpretations that are far from scientifically rigorous. This trend seems to be partly linked to the institutionalisation and, in particular, the increasing medicalisation of prevention strategies, within which the real participation of the people concerned is diminishing, and with it the knowledge of the reality of the different communities. We are seeing a resurgence in the pathologisation of behaviour. Multi-partner gay sex is presented as "compulsive and irrepressible consumption of partners" or even "sexual addiction". All consumption is presented as "substance abuse", the first step on "the slippery slope" with "increasingly hard products, taken more and more often and/or in greater and greater quantities", leading to "inescapable dependence/addiction", with death as the only possible outcome. This sexuality and/or consumption is presented as the answer found by "psychologically damaged people" to fill "a void (of meaning) in their lives" or some other "narcissistic wound" and that these "vulnerable people (by nature)" need to be saved from themselves.

These attitudes fail to take into account the huge diversity of people and situations and, even less, the resources they have at their disposal and the strategies they have put in place themselves. The majority of gay-bi men and other MSM are doing quite well. However, some members of this group, and of LGBTIQ+ communities more generally, are experiencing biopsychosocial difficulties. This happens more frequently than in the rest of the population, as it is often linked to minority stress and negative experiences in their lives. Some LGBTIQ+ people may therefore need support that takes into account issues relating to gender and sexual orientation and the specificities associated with the intersection with substance use – particularly sexualised substance use – in a community cultural context full of resources. Unfortunately, appropriate services in this area are still rare and difficult to access, due to overload and/or difficulties in providing care.

What we need today to respond adequately to the issues related to sexualised consumption and Chemsex does exist, but there are obstacles to its proper implementation and deployment:

Objectively inform communities about harm reduction products and strategies, using materials developed with the people concerned to reflect their realities and take advantage of their knowledge and skills.

Provide real access to appropriate tools and services:

– Safer sex and safer use material.

– Integrated sexual health services: information and advice; vaccinations; screening and monitoring; emergency, preventive and therapeutic HIV care; treatment for other STIs and consultations for viral hepatitis; sexology and couples…

– Drug checking, including using the NIRLab (see box).

– Non-pathologising individual support for LGBTIQ+ people, particularly gay-bi men and other MSM.

– Individual support for drug users, from harm reduction advice to addiction therapy.

– Collective support and peer self-support groups in a space free from social, moralistic and pathologising stigma, including within the community.

In order to respond effectively to people's real needs, services must be defined and implemented from a non-judgmental, non-pathologising stance and correspond to community cultures.

In order to reach as many people as possible, these services need to be deployed as close as possible to the people concerned, particularly in community spaces, and even in private places: information, screening and drug checking activities in community spaces, including outside urban centres. To achieve this, all legal and institutional barriers must be removed.

Carry out regular and appropriate monitoring of drug use and sexual relations under the influence of drugs, particularly chemsex, as well as profiles of the people involved and incidents. This can be done by periodically analysing data collected over time (BerDa, Swiss HIV Cohort Study, SwissPrEPared, Drug Checking, analysis of seized products and wastewater, data from emergency and health services) and by periodic population surveys that are as representative as possible (Swiss Health Survey, Sexual Health Survey, LGBT Survey, etc.).

Involving people who use sexual substances, especially those who practise chemsex, is essential in research to ensure that questionnaires and data analyses are appropriate, that questionnaires are widely distributed and that the results are understood and, if necessary, supplemented by qualitative studies that can shed light on the individual and social dynamics involved. Evaluation of the appropriateness and effectiveness of measures and services should also be implemented as part of a participatory process.

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