REACHING OUT TO CHEMSEXERS

A GUIDE
TO IMPLEMENTING
A MULTIDISCIPLINARY
APPROACH

ACRONYMS

AERLI	ACCOMPAGNEMENT ET ÉDUCATION AUX RISQUES LIÉS À L'INJECTION Injection risk support and education
ARPA	ACCOMPAGNEMENT EN RÉSEAU PLURIDISCIPLINAIRE AMÉLIORÉ Support through an improved multidisciplinary network
ARS	AGENCE RÉGIONALE DE SANTÉ Regional health agency
CAARUD	CENTRE D'ACCUEIL ET D'ACCOMPAGNEMENT À LA RÉDUCTION DES RISQUES POUR USAGERS DE DROGUES Harm reduction drop-in and support centre for drug users
CEGIDD	CENTRE GRATUIT D'INFORMATION, DE DÉPISTAGE ET DE DIAGNOSTIC Free information, screening and diagnostic centre
COPIL	COMITÉ DE PILOTAGE Steering committee
COREADD	COORDINATION RÉGIONALE ADDICTIONS Regional addiction coordination service
CPTS	COMMUNAUTÉ PROFESSIONNELLE TERRITORIALE DE SANTÉ Territorial professional health community
CSAPA	CENTRE DE SOIN, D'ACCOMPAGNEMENT ET DE PRÉVENTION EN ADDICTOLOGIE Addiction care, support and prevention centre
DASA	DÉPENDANTS AFFECTIFS SEXUELS ANONYMES Anonymous sexual emotional dependents
FA	FÉDÉRATION ADDICTION
FLCA	FONDS DE LUTTE CONTRE LES ADDICTION Addiction Prevention Fund
MILDECA	MISSION INTERMINISTÉRIELLE DE LUTTE CONTRE LES DROGUES ET LES CONDUITES ADDICTIVES
MSM	Men who have sex with men
OFDT	OBSERVATOIRE FRANÇAIS DES DROGUES ET DES TENDANCES ADDICTIVES French monitoring centre for drugs and drug addiction
PLHIV	People living with HIV
PPC	Person practicing chemsex
PREP	PROPHYLAXIE PRÉ-EXPOSITION Pre-exposure prophylaxis
RPIB / EIBI	REPÉRAGE PRÉCOCE ET INTERVENTION BRÈVE Early Identification and Brief Intervention (EIBI)
STI	Sexually transmitted infection
TASP	TRAITEMENT EN TANT QUE PRÉVENTION Treatment as prevention (U = U : Undetectable = Untransmittable)

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FÉDÉRATION ADDICTION
Prévenir | Réduire les risques | Soigner

The Fédération Addiction is a network of associations and professionals working in the field of addiction. The Federation's mission is to develop appropriate, user-centred responses to addiction. It is the leading network in the field of addiction in France, with a membership of 850 health institutions and services and more than 500 individual members (professionals involved in care, education, prevention, support and harm reduction).

AIDES
MILITER · AGIR · TRANSFORMER
MEMBRE DE COALITION PLUS

Founded in 1984, AIDES is the leading organisation in France and Europe in the fight against AIDS and hepatitis. It is recognised as a public charity and has been awarded the 'Don en confiance' label by the Comité de la Charte. For 40 years, AIDES has been working with and for the populations most affected by HIV/AIDS and hepatitis, to reduce new infections and help those affected to access treatment and defend their rights. More broadly, the association plays a major role in improving the way patients are considered in the French healthcare system, extending the rights of vulnerable people and fighting discrimination.

PRÉFACE

Introduction to the ARPA (Accompagnement en réseau pluridisciplinaire amélioré [support through an improved multidisciplinary network]-Chemsex Implementation Guide

The phenomenon of chemsex, which has emerged over the last decade or so and mainly affects men who have sex with men (MSM), has become more visible, particularly because of the Covid-19 crisis, which has triggered a number of behavioural changes. Despite the efforts of community associations to monitor the phenomenon, the private and intimate nature of the issue makes it difficult to collect the data needed to make a reliable assessment. As a result, chemsex poses a serious threat to public health, involving multifactorial risks, the most obvious of which are drug addiction, the risk of overdose, the risk of altered consent, and risky sexual behaviour leading to a possible increase in the spread of sexually transmitted infections (STIs).

However, there are other components, causes and consequences that should not be underestimated, such as stigma, social exclusion and loneliness, as well as the specific problems of the individuals involved, which can exacerbate pre-existing mental health problems or those arising from the use of these substances in a sexual context, creating a vicious circle that can only be broken through appropriate intervention.

To address these issues, the ARPA-Chemsex project's strategy of developing a comprehensive response that includes sexual health, addiction and mental health issues for people who practise chemsex was in line with our expectations, both in terms of adapting and promoting local initiatives led by community associations and local authorities. Accordingly, the public authorities, including the French Ministry of Health, have supported the project through the Fonds de lutte contre les addictions (FLCA, Addiction Prevention Fund), with the practical aim of bringing together prevention, risk and harm reduction, pathways and referrals to care through the creation of regional networks.

The 2021–2024 roadmap for the national sexual health strategy supports this dynamic. Among its priority actions is one dedicated to improving the identification and management of chemsex, confirming its importance as a public health issue for the Ministry of Health. This initiative is based on the ARPA-Chemsex project and the report by Professor Amine Benyamina. In addition, the latest edition of the 'Contexte des sexualités en France' (Context of sexuality in France) survey, which is currently being finalised, includes questions on the practice of chemsex for the first time. Its broad panel (more than 37,000 people aged 15 to 89, including 10,000 in the French overseas departments and territories) will make it possible to assess the extent of the phenomenon and its potential spread to a wider public than is currently perceived. Building on these different elements, the next sexual health roadmap will provide an opportunity to take complementary action to meet the local and population needs that may arise from this practice, through a holistic approach covering sexual health, mental health and addiction prevention.

As such, this companion guide provides a first opportunity for any structure wishing to manage chemsexers within this multidisciplinary model and is an essential tool for its implementation. It is hoped that the experience and good practice gained in the field through the project will create dynamic networks between the various medico-social structures involved (CeGIDD, CSAPA, CAARUD), community associations and frontline doctors to better prevent and manage these risky practices.

We wanted to use this small contribution as a reminder of our support and the involvement of the public authorities in tackling this phenomenon, to develop appropriate and inclusive responses, deepen our understanding of the problem of chemsex and develop sustainable solutions to deal with it.

DR GRÉGORY EMERY
Director General, Ministry of Health

FOREWORD

For more than a decade, the practice of chemsex has raised questions and often concerns among sexual health and addiction professionals, community activists and, most importantly, those directly involved. Addressing chemsex issues means exploring new ritualised sexual practices under the influence of illicit psychoactive substances, seeking to understand the determinants of use, analysing the desired and undesired effects of these substances, and developing appropriate sexual prevention and risk reduction strategies.

The risks of chemsex are not all addiction related. Infectious issues (including hepatitis C virus contamination), sexual and mental health problems are integral to the concerns of both chemsexers and frontline workers. Supporting chemsexers is therefore a multidisciplinary task involving several different sectors: addiction, community health, sexual and infectious health, mental health and so on.

Nowadays, chemsex seems to have become a sexual practice in its own right. The number of people involved is increasing and the practice is spreading across all age groups and regions.

There are no easy solutions to prevent people from taking drugs and becoming addicted. But one thing is certain: discrimination, stigmatisation and punishment of users are detrimental to a proper understanding of the phenomenon and to the provision of appropriate care for people in difficulty or at risk. Because in this field, as in those we deal with on a daily basis, the approach is different: it's about information, prevention, support and guidance, not punishment.

In this context, it is important to mention that homophobic violence, psychological trauma and the difficulty of finding one's sexuality in a society and community characterised by the idea of performance are all obstacles to be overcome that contribute to the dynamics of these practices. These difficulties have been exacerbated by the health crisis associated with Covid-19.

AIDES and the Fédération Addiction decided to adopt a multidisciplinary network approach thanks to the ARPA (Accompagnement en réseau pluridisciplinaire amélioré)-Chemsex project, supported by the Fonds de lutte contre les addictions (FLCA, Addiction Prevention Fund). The complementarity between medical and social structures specialising in addiction and community health workers involved in sexual prevention and risk reduction has helped to strengthen professional skills and better meet the needs identified by those affected. This three-year experience has also enabled us to assess the level of support for this strategy among the people concerned, to identify the missing methods and tools, and to improve the overall health status of chemsexers and their quality of life.

This guide has been produced based on our experiments, the needs expressed by chemsexers and the responses initiated by the pilot sites and will help you to provide the best possible welcome for chemsexers.

Many thanks to all the authors and contributors to this guide.

CATHERINE DELORME,
President of the Fédération Addiction

CAMILLE SPIRE,
President of AIDES

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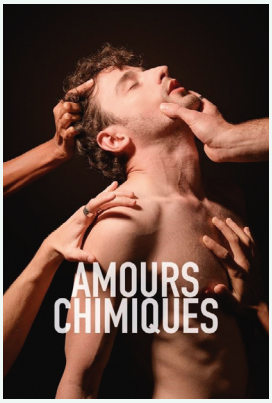
ESTABLISHING MULTIDISCIPLINARY PATHWAYS TO SUPPORT CHEMSEXERS: A PRACTICAL GUIDE

‘THE FIRST TIME I HEARD ABOUT CHEMSEX WAS ON GRINDR, BUT I DIDN’T QUITE UNDERSTAND WHAT THEY WERE ASKING ME TO DO... “CHEMS PLAN”.
I WAS SO NAIVE THAT I THOUGHT IT WAS JUST SLANG FOR “CHEUM” AND THAT I WAS BEING OFFERED A BOOTY CALL BETWEEN UGLY PEOPLE, I FELT QUITE OFFENDED’.”[1]

This guide is the result of the “Accompagnement en réseau pluridisciplinaire amélioré – Chemsex” (ARPA-Chemsex, Support through an improved multidisciplinary network) project, carried out over three years by AIDES and the Fédération Addiction with the support of the FLCA (Addiction Prevention Fund).



[1] The quotations in italics are from the play “Amours chimiques”, written and directed by Corentin Hennebert and Josef Wolfsohn. You will find them throughout this guide.

CHEMSEX: A PHENOMENON COMBINING SEXUALITY AND THE USE OF PSYCHOACTIVE SUBSTANCES

For almost fifteen years, those working in the field of sexual health and addiction have been confronted with increasing demands for support and care from homosexuals or other men who have sex with men (MSM) involved in chemsex.

→ See the recent publication of the Observatoire français des drogues et des tendances addictives (OFDT, French monitoring centre for drugs and drug addiction) (see page 10 for details).

The use of substances for sexual and social purposes is not a new phenomenon, and drug use in a sexual context has been documented among MSM long before the term "chemsex" was invented.

In fact, there is no single definition of chemsex, but all agree that the practice is characterised by:

→ the use of substances to facilitate, prolong or enhance sexual relations;
→ the use of a specific range of substances (mainly stimulants and GHB [gamma-hydroxybutyrate] / GBL [gamma-butyrolactone]);
→ occasional and often multiple sexual partners (group sex);
→ '[sex] sessions' lasting for a long time, up to several days;
→ the increasing importance of digital technology and location-based dating apps for recruiting partners and purchasing consumables.

The increasing number of partners, the use of multiple drugs simultaneously (poly-drug use and interactions) and injecting drugs can expose people to physical and psychosocial risks.

The vagueness of chemsex makes it difficult to quantify, but prevalence rates can be as high as 30% in some active MSM files.

→ See box 'Overview of current knowledge' on page 12.

Health restrictions during the Covid-19 pandemic (confinement, curfews, closure of party venues, etc.) led to an increase in chemsex practices and may have exacerbated them by exposing chemsexers to risks without professional support.

People use drugs in a sexual context to reduce their sexual inhibitions, manage their shyness, boost their confidence or fulfil their fantasies, while increasing the pleasure and duration of their sexual activities. Beyond these commonly cited motivations, it is impossible to understand the reasons for its spread without also considering the specific issues affecting the gay community: the burden of HIV among them, homophobic stigmatisation, and so on.

ORIGINS OF THE ARPA-CHEMSEX PROJECT

The ARPA-Chemsex project is the result of constant and regular exchanges between the Fédération Addiction and AIDES. The partnerships set up in certain regions between the Fédération Addiction's medico-social structures and the AIDES sites have demonstrated the advantages of combining AIDES's community-based services with the medico-social services provided mainly by the CSAPAs (Centres de soin, d'accompagnement et de prévention en addictologie *[Addiction care, support and prevention centre]*) and CAARUDs (Centres d'accueil et d'accompagnement à la réduction des risques pour usagers de drogues *[Harm reduction welcome and support centre for drug users]*), in order to improve the care and support of chemsexers. In this context, the two associations decided to develop a project that would build on and strengthen their existing experience. It was decided to work with the cities of Marseille, Bordeaux and Paris, where partnerships had already existed for a number of years.

The project was submitted under the 2020 call for projects of the Fonds de lutte contre les addictions (FLCA, Addiction Prevention Fund). The FLCA decided to provide funding for one year in order to fine-tune the project's objectives and methodology. This was made possible by mobilising various working groups and a steering committee. Finally, the revised version of the ARPA-Chemsex project was approved at the end of 2021, with a funding period of three years.

PRESENTATION OF OBJECTIVES AND METHODOLOGY

OBJECTIVES

GENERAL OBJECTIVE:

To improve multidisciplinary sexual prevention and harm reduction services for chemsexers.

SPECIFIC OBJECTIVES:

→ Identify the invariable characteristics of multidisciplinary support based on the synergies between community and medico-psychosocial approaches to addiction.
→ Help six regions in the implementation and strengthening of multidisciplinary support for chemical dependency.
→ Improve the tools and strengthen the skills of professionals working in the field of chemsex.
→ Disseminate the tools to professionals and service providers.

EVALUATION

An external evaluation of the project was carried out by the consultancy firm Planète publique, using a qualitative, pluralist (through discussions with the various stakeholders) and participatory approach. It aimed to answer three questions:

→ What are the needs and expectations of professionals in terms of coordination and networking?
→ How can the system be implemented in areas where needs have been identified?
→ How can we build a sustainable implementation model based on common success factors?

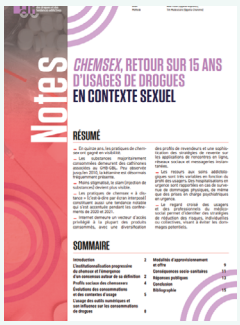
The evaluation sought to observe the way in which the actions were implemented and to compare the expected results with the actual results achieved.

MONITORING

Each pilot site identified a pair of project coordinators who worked together to develop joint local initiatives between the AIDES site and the Fédération Addiction partner organisation.
At national level, two coordinators (one from AIDES and one from Fédération Addiction) monitored the project at global level and provided support services to the pilot sites.
The project was also supported throughout by a steering committee (Comité de pilotage – Copil [Steering committee]), made up of:

→ Laurent Passalacqua, Administrator; Stéphane Giganon, Quality Approach Manager; Joseph Situ, Priority Populations Manager; David Michels, Innovation and Programmes Manager; Fred Bladou, Project Manager (for AIDES).
→ Jean-Michel Delile, Past President; Muriel Grégoire, Administrator; Marine Gaubert, in charge of professional practices; Jonathan Rayneau, Project Manager (for the Fédération Addiction).
→ Sylvain Guého (Direction générale de la santé [General Health Department])
→ Annie Velter (Santé publique France)
→ Ruth Gozlan (Mission interministérielle de lutte contre les drogues et les conduites addictives – MILDECA)
→ Yasmina Nicolas, Pol Prévost-Monsacré and Paola Fourcaud (Planète Publique)
→ Representatives of the regional health agencies for the areas concerned.

The Copil was assisted by the following resource persons: Dr Alexandre Aslan (Hôpital Saint Louis – APHP), Dr Jérôme Bachellier (ELSA France), Nicolas Bonnet (Respadd), Pr Laurent Karila (Hôpital Paul Brousse – APHP), Dr Gonzague de Larocque-Latour (Réseau de Santé Sexuelle Publique) and Dr Dorian Rollet (Hôpital Lariboisière Fernand Widal – APHP).


Notes
CHEMSEX, RETOUR SUR 15 ANS D'USAGES DE DROGUES EN CONTEXTE SEXUEL
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Publication reference: Gérome C., Milhet M., Tissot N., Madesclaire T. (2024) Chemsex, retour sur quinze ans d'usages de drogues en contexte sexuel. Note de résultats. Paris, OFDT, 17 pages.

METHODOLOGY AND SUCCESSIVE PHASES

PHASE 1 — 2022

- Review of practices, barriers and levers for multidisciplinary support services in three sites with existing services (Aix-Marseille, Paris, Bordeaux)
- Draft guidelines for multidisciplinary care and support services for chemsexers
- Preparation and launch of the call for applications for three new sites
- Selection of the evaluator

PHASE 2 — 2023

- Implementation of new and innovative initiatives to strengthen existing services in the three Phase 1 sites
- Take stock of the situation in the three new sites (Lyon, Lille, Montpellier)
- Recruit and support the three new sites in implementing multidisciplinary support
- Develop communication tools
- Pooling of practices between the six sites

PHASE 3 — 2024

- Strengthen the expertise of staff in the six pilot sites
- Develop an implementation guide
- Organise a national feedback day
- Feedback on the evaluation

THE SIX PILOT SITES

THE 3 PHASE 1 PILOT SITES

Aix-Marseille: the AIDES SPOT Longchamp and the CSAPA Villa Floréal, managed by the Montperrin hospital;
Bordeaux: the AIDES site and the CSAPA and CAARUD, managed by the Comité d'étude et d'information sur la drogue et les addictions (CEID-Addictions);
Paris: AIDES SPOT Beaumarchais and Checkpoint, in partnership with the Groupe SOS CSAPA Monceau.

THE 3 PILOT SITES INVOLVED IN PHASE 2

Lille: the AIDES site hosting a CAARUD and the CAARUD run by the Spiritek association[2]
Lyon: the AIDES site and the CAARUD Pause Diabolo run by the association Le Mas;
Montpellier: the AIDES SPOT and the Axess CAARUD run by the SOS group.

Each pilot site received €50,000 to support its participation in the project.

WHO CAN USE THIS GUIDE AND WHAT IS IT FOR?

This guide is intended for all those working in the field of sexual health and addiction who have or may have chemsexers in their active file and who wish to set up a specific service for this group:

- → teams working in CSAPAs and CAARUDs, hospital addiction units, AIDES focal points, CeGIDDs (centre gratuit d'information, de dépistage et de diagnostic – free information, screening and diagnostic centres), hospital infectious diseases and addiction units, etc.;
- → staff and volunteers from LGBTQIA+ community associations, anti-HIV organisations, sex workers' organisations, drug users' self-help groups, etc.

This guide is designed to help individuals and organisations set up multidisciplinary support services.

The guide consists of four parts, enriched with personal accounts and texts by professionals involved in the discussion of chemsex issues, as well as presentations of practical initiatives implemented by the pilot sites. It is designed to help the many different actors to build their services in partnership, while focusing on the essential elements of support for chemsexers.

Each part can be read as a stand-alone study:

- → the first part sets out the methodological steps involved in implementing a multidisciplinary, community-based support project;
- → the second part deals with sexual health and the specific issues for chemsexers;
- → the third part looks at drug-related risk reduction and how this applies to chemsex products and practices;
- → the final part deals with addressing the mental health needs of chemsexers.

[2] The Spiritek association was involved in the project for a year.

OVERVIEW OF CURRENT KNOWLEDGE

PERRINE ROUX
(Inserm, Marseille),

ANNIE VELTER
(Santé publique France, Saint-Maurice)

The phenomenon of 'chemsex' first appeared about fifteen years ago and is characterised by the use of sexualised drugs within the gay community, as described by David Stuart, an activist defending the rights of men who have sex with men (MSM) (Stuart, 2016). [3] Although this practice existed long before the term 'chemsex' was introduced, its characteristics are recognised by the communities involved and those working with them on the ground: the use of psychoactive substances such as cathinones, GHB/GBL or methamphetamine in a sexual context, mainly in groups and over relatively long periods.

Available data from scientific studies, feedback from the field and the Benyamina report [4] show that this practice is spreading in many countries (Blomquist et al., 2020; Bourne et al., 2015; Frankis et al., 2018; Herrijgers et al., 2020). According to a systematic review published in 2019, the prevalence of MSM in many countries (Western Europe and North America) ranges from 3% to 29% (Maxwell et al., 2019). The highest estimates come from studies conducted in sexual health centres or among users of location-based dating apps. Therefore, these highly variable prevalence data depend not only on the populations surveyed (Edmundson et al., 2018; Elliot et al., 2017; Flores Anato et al., 2022; Roux et al., 2022), but also on the questions asked to identify the practice of chemsex.

The first studies carried out in the United States and the United Kingdom documented the numerous medical complications associated with chemsex: somatic and infectious diseases (HIV, HCV, STIs, abscesses, venous damage, overdoses), psychological problems (drug-related impairment, lack of self-esteem) and social problems (loss of employment, isolation) (Halkitis et al., 2001; Mansergh et al., 2006; Ruf et al., 2006; Rusch et al., 2004). In addition, work carried out during the Covid-19 epidemic suggests that the health crisis had a very negative impact on people who practise chemsex (Roux et al., 2022; Santos et al., 2021), particularly in terms of access to HIV screening and prevention (de la Court et al., 2023). In France, available data suggest that the prevalence of chemsex among MSM varies between 5 and 12% (Velter et al., 2023).

While this pattern of drug use in a sexual context is quite different from other types of drug use, such as traditional drug use ('old school users') (Melendez-Torres et al, 2018), results from the ANRS-PaacX and APACHES cross-sectional studies show that there are different practices and relationships with chemsex. Data from the ANRS-Prévenir cohort describe three different trajectories of chemsex among Prep users: an increasing frequency of practice, a decreasing practice and a stable practice over time, each with different profiles (Sietins, AIDS Impact, 2024). Similarly, there can be several ways of experiencing chemsex, ranging from the most positive (hedonistic) to the most problematic (destructive) (Protière, AFRAVIH, 2022). Therefore, despite the complications associated with the practice, it is also important to explore the pleasures and functions of chemsex in order to shed new light on it (Freestone et al., 2022; Race, 2009). Several recent reviews of the literature provide important insights into the realities of chemsex and its motivations (Hawkinson et al., 2024; Lafortune et al., 2021; Marques Oliveira et al., 2023).

While the first authors to address chemsex recognise the cultural specificity of the practice, which is rooted in the gay community (Stuart, 2019), there is little data on the role of chemsex in the social lives of MSM populations with multiple forms of vulnerability, such as migrant MSM, trans people, young MSM (Tan et al., 2021) or older MSM. For example, while community associations report the same difficulties in accessing migrant MSM populations, they also describe the situation of migrant chemsexers as being affected by multiple vulnerabilities (administrative insecurity, difficulties in accessing their rights and health care, social isolation, psychological problems, etc.), which may increase restrictions on sexuality and reduce the choice of sexual practices. Qualitative research has also shown the importance of sexual (re)socialisation in the trajectories of foreign-born MSM in exile (Chen, 20-23; Mole et al., 2017), and chemsex practices may form part of this (re)socialisation.

Pharmacovigilance data, reports of medical treatment and user testimonies all point to the continuing evolution of chemsex practices. While in many countries the main substances used in chemsex are methamphetamine and GHB/GBL, in France it is mainly cathinones that are associated with this trend, also together with GHB/GBL (Chas et al., 2021; Freestone et al., 2023). The emergence of new synthetic products and the ongoing market transformation

therefore require appropriate harm reduction responses, including wider access to drug analysis.

Despite low condom use and risky STI and HCV practices, people who practice chemsex have adopted certain HIV and STI prevention strategies (O'Halloran et al., 2019; Roux et al., 2018). While data are more often collected from HIV-negative MSM (ANRS-Prévenir), other studies (APACHES, ANRS-PaacX, ERAS) have shown that people living with HIV (PLHIV)[5] are also involved in chemsex activities. Some studies even show that MSM living with HIV are more involved in chemsex than HIV-negative MSM (Pufall et al., 2018), but this trend is decreasing with the advent of Prep.

MSM living in rural areas may not benefit from the same range of prevention and care services, or from the same associative and community environment, which could influence the risk reduction practices and strategies implemented. Moreover, the living conditions of MSM in rural areas may affect their quality of life and mental health (isolation, homophobia). The benefits of distance or correspondence-based harm reduction could be as beneficial for sexual health as for drug use, as demonstrated during the Covid-19 period with the SAFE association (Torres-Leguizamon et al., 2023).

Regardless of a person's relationship with chemsex and the level of risk associated with their practices, chemsexers have specific and ever-changing health needs that require the implementation of a tailored care pathway (Blanchette et al., 2023; Hibbert et al., 2019). Testimonies from associations and chemsexers attest to the practice of chemsex among trans people, both men and women. However, these populations are barely visible in quantitative surveys of the phenomenon, and the available data are often too limited to interpret. We also know that this is a population that is exposed to specific forms of violence, particularly transphobic violence, and to social vulnerabilities that have somatic and mental health consequences.

All these findings reinforce the need to adapt and diversify responses to chemsex in terms of care, prevention and harm reduction. They also call for continued research to better understand the nature of sexualised drug use and to identify relevant interventions.

[3] A list of references for all contributions is provided in the appendix.

[4] Ministry of Solidarity and Health. "Remise du rapport du Pr Amine Benyamina portant sur l'usage de drogue dans le cadre du 'chemsex' au ministère des Solidarités et de la Santé [Submission of the report by Prof. Amine Benyamina on the use of drugs in the context of 'chemsex' to the Ministry of Solidarity and Health]". Press release, 17 March 2002. https://sante.gouv.fr/IMG/pdf/2022_03_17_cp_rapport_chemsex_vdef.pdf

“One day I turned up at a guy’s house, he hadn’t told me, but there were already four of them, all completely stoned…”

A CLINICIAN GIVES HER TESTIMONY

DR MURIEL GRÉGOIRE
Psychiatrist,
Addiction counsellor,
Villa Floréal CSAPA, SPOT Longchamp counsellor, chemsex counsellor for the Fédération Addiction

“While the main motivation for practising chemsex is the search for pleasure and new sensations, more specific factors related to the gay community also come into play”

“My many meetings and interviews over the past ten years have helped me to understand the key factors behind problematic use. Feedback from those affected is essential in our work to understand and help patients, so that we can build an inter-subjective, trusting and non-judgmental relationship.

If the main driver for practising chemsex is the search for pleasure and new sensations, some more specific factors for the gay community come into play and may prove more decisive if use becomes problematic or even addictive. These factors combine personal, social and behavioural influences.

As the practice becomes more commonplace in the gay community, across all social classes, it is increasingly destigmatised, giving newcomers a sense of security.

The internet is a major catalyst in a society that encourages hyper-consumption. Dating apps provide partners and online commercial sites provide products, allowing chemsex to proliferate. Video screens also provide a degree of protection during desirable but somewhat dreaded encounters. Emotions are put aside, dating via apps avoids taking risks and, above all, the number of partners reassures people about their potential for seduction at times. The search for affection, which involves emotional deprivation and feelings of rejection, is rarely satisfied and can lead to endless repetition.

An excessive attachment to gender identity can lead to unhappiness, as it is underpinned by diktats about beauty, achievement, age, drug use and uninhibited sex with multiple partners. The feeling of being outside the community if you do not meet these requirements can lead to conflicting feelings and behaviours. Chemsex can provide a gateway to these feelings. Products and dating applications make it easier to seduce, meet and perform.

One of the factors most often identified as exacerbating other social conditions is loneliness, which is more common in gay groups. The search for companionship can be an excuse to go to chemsex parties.

Homophobia is still very present and can lead to lifelong abuse and suffering. As a result, there is a risk of excessive consumption in covert sexual contexts, sometimes experienced with considerable guilt, triggering a new spiral of consumption. Sex is perceived as transgressive and secret from the very first relationships, resulting in a tendency to live their sexual lives accordingly. Internal homophobia, caused by homophobia in some people, reinforces this situation and can prevent them from being themselves: hiding their sexual orientation and assuming their sexuality through drugs and screens (videos, dating) or, on the other hand, assuming a gender identity in order to fit into a certain community instead of complying with the proposed codes. Emotional relationships require further exploration as it can be difficult to find one’s place between heteronormative and libertarian codes.

Chemsex allows you to accept your sexuality and discover the passive side of it. The products reduce erections and increase the duration and intensity of arousal, always postponing the pleasure that can be expected for days and nights.

HIV has shaped the community since the 1980s, creating fear, rejection and stigma within society and even within the community. The proportion of HIV-positive chemsexers is significant, and even more so among slammers.[5] In most cases, injecting takes place after the discovery of HIV infection. Initially undetectable antiretroviral treatment, followed by Prep, has liberated the sexuality of people living with HIV, who are now less stigmatised. However, serophobia still exists, even in the community, and can lead people to hide their true selves due to a lack of self-confidence and a sense of rejection, a breeding ground for excessive use.

Ordeal-like behaviour (risking death to feel alive, questioning one's fate in a fantasy of omnipotence) persists among people living with HIV (what more can you risk?), leading them to engage in risky drug use.

The products are powerful, with a strong dopaminergic effect that encourages compulsive use and is highly addictive. Users say they have exciting and aphrodisiac properties, are easy to obtain and affordable.

Psychological factors more common in other addictions are also widespread: obsessive personality disorder, a need to be overly demanding or even hypernormal. Chemsex offers people a chance to let go. Borderline personality disorder, mood disorders, anxiety disorders and attention deficit hyperactivity disorder (ADHD) are vulnerability factors.

Violence, psychological or physical abuse, trauma related to sexual abuse, emotional deprivation, death or separation during childhood are also very common".

[5] Definition of slam on p.41.

PART 1

DEVELOPING SPECIFIC INTERVENTIONS FOR CHEMSEXERS

"I STARTED PRACTISING CHEMSEX DURING THE FIRST LOCKDOWN IN FACT, I'VE NEVER HAD AS MANY 'TOUZES' (GROUP SEX) IN MY LIFE AS I DID DURING THAT TIME"

This part outlines the key steps and requirements for setting up initiatives to support chemsexers. This guide is based on the principles of the community health approach and on initiatives in the ARPA-Chemsex pilot sites.
These elements will guide you through the development of your project.

Chemsexers suffer double stigma, firstly because of their sexual orientation and sexuality, and secondly because of their drug use. They experience rejection and stigma (within the community) and their social, emotional and sexual lives are shaped in a harmful and damaging context.

To address these difficulties, professionals need to adapt their approach to chemsexers by developing a project methodology that works:

→ step-by-step;
→ with a multidisciplinary group of partners and actors;
→ according to the local context.

FOCUS ON THE ESSENTIAL STEPS

There is one absolute prerequisite for developing initiatives targeted at chemsex workers:

You need to have identified chemsexers among the population you encounter in the course of your activities.

BEST PRACTICES FOR IDENTIFYING CHEMSEXERS IN YOUR ACTIVE FILES

→ Adapt your reporting tools (interviews, data collection): add chemsex-specific indicators.

→ Enable your organisation to be identified by chemsexers: thematic display in your premises, communication with partners, creation of communication media, actions outside your organisation to reach chemsexers, etc.

→ Receive information and training on chemsex.

DIAGNOSING THE NEEDS OF CHEMSEXERS...

You need to identify the specific needs of the chemsexers you meet in order to develop a tailored service. The guidelines document reproduced in the appendix, which formed the basis of the ARPA-Chemsex project, can be used as a basis for this assessment. It was developed and approved by the main stakeholders (Fédération Addiction, AIDES, pilot sites and members of the Steering Committee).

The assessment can be carried out using quantitative methods (questionnaires, analysis of internal or local data) or qualitative methods (individual or group interviews, literature review).

FURTHER INFORMATION:
see attached guidelines

Some examples of good practice include:

→ drawing up a methodological note to define the questions to be answered, the indicators needed to answer them and the deadlines for the work;
→ inviting chemsexers to work meetings;
→ design a data collection tool with the chemsexers you meet;
→ build a tool to centralise data beforehand (example: Excel spreadsheet);
→ test your data collection tool before you start using it;
→ ask neutral questions.

... AND THE EXISTING LOCAL STRUCTURES

The aim of this assessment is to characterise the existing structures in the area. The following steps are recommended:

→ mapping the actors involved, characterising their functioning and their role (private practitioners, institutions and local authorities, community associations, addiction, medical, medico-social institutions, etc.);
→ observing the resources made available by these structures (public targeted, services offered);
→ exchanging views with them in order to assess their willingness to support chemsexers.

On the basis of this situation analysis, it will be possible to assess the extent to which services in the region are complementary and to identify the partnerships needed to provide comprehensive health support:

→ action partnerships
→ guidance partnerships.

ADDICTION AND SEXUAL HEALTH ORGANISATIONS TO CONTACT IN YOUR AREA:

ADDICTOLOGY

CSAPA

CENTRE DE SOIN, D'ACCOMPAGNEMENT ET DE PRÉVENTION EN ADDICTOLOGIE
(ADDICTION CARE, SUPPORT AND PREVENTION CENTRE)

→ They are run by an association or a hospital.
→ Some also provide residential care: **CT** (communauté thérapeutique – therapeutic community); **CTR** (centre thérapeutique résidentiel or CSAPA-résidentiel – residential therapeutic centre or residential CSAPA); **AT** (appartement thérapeutique – therapeutic apartment); **RAF** (réseau d'accueil en famille – family reception network).

CAARUD

CENTRE D'ACCUEIL ET D'ACCOMPAGNEMENT À LA RÉDUCTION DES RISQUES POUR USAGERS DE DROGUES (HARM REDUCTION WELCOME AND SUPPORT CENTRE FOR DRUG USERS)

HOSPITAL ADDICTION SERVICES

ELSA

ÉQUIPE DE LIAISON ET DE SOINS EN ADDICTOLOGIE
(ADDICTION LIAISON AND SUPPORT TEAM)

CONTACT DETAILS AVAILABLE AT:
https://www.drogues-info-service.fr/Adresses-utiles

DIRECTORY OF RESIDENTIAL CARE FACILITIES AVAILABLE AT:
www.federationaddiction.fr

OTHER USEFUL CONTACTS:
The specific regional addiction unit or centre of resources and expertise on drug use and addiction in your region (e.g. Coreadd Nouvelle-Aquitaine, 2PAO in Occitanie, Hauts de France Addictions, ARCA-Sud, etc.).

SEXUAL HEALTH

CORESS

COMITÉS DE COORDINATION RÉGIONALE DE LA SANTÉ SEXUELLE
(Anciens COREVIH : Coordination régionale de lutte contre le VIH)
Regional sexual health coordination committees
(Formerly COREVIH : Regional HIV coordination)

CSSAC

CENTRE DE SANTÉ SEXUELLE D'APPROCHE COMMUNAUTAIRE
(COMMUNITY-BASED SEXUAL HEALTH CENTRE)

CEGIDD

CENTRE GRATUIT D'INFORMATION, DE DÉPISTAGE ET DE DIAGNOSTIC (FREE INFORMATION, SCREENING AND DIAGNOSTIC CENTRE)

SMIT

SERVICE DES MALADIES INFECTIEUSES DES HÔPITAUX
(HOSPITAL INFECTIOUS DISEASES SERVICE)

PREVENTION AND SEXUAL HEALTH STRUCTURES

You can also contact LGBTQIA+ community and self-help associations, HIV organisations such as AIDES, and mental health services.

The regional health agency (agence régionale de santé – ARS) and the territorial professional health community (communauté professionnelle territoriale de santé – CPTS) in your area can help you identify these structures.

FURTHER INFORMATION:
ARS and CPTS websites

CONSIDERING A COMPREHENSIVE, COMMUNITY-BASED APPROACH

COMMUNITY APPROACH TO HEALTH: DEFINITION

The community approach to health is a way of designing public health projects that involve a group of people (the community) working to improve their health. It involves:

- → a process of active participation by all stakeholders, from design to evaluation;
- → a comprehensive approach, covering all key health determinants (housing, environment, culture, education, employment, access to information, etc.);
- → a collective commitment to defending people's rights.

The community-based approach allows chemsexers to talk openly and without judgement about their drug use and sexuality. This approach is based on a number of principles: trust, confidentiality, non-judgement, empathy and reciprocity.

As in the needs assessment phase, it is essential to involve chemsexers in the design of services for them. Some good practices are listed below:

- → inviting chemsexers to work meetings;
- → organising subject-specific workshops;
- → creating a welcoming atmosphere that encourages discussion;
- → leaving enough space for chemsexers in attendance to have their say;
- → providing symbolic compensation (e.g. payment, reimbursement of expenses, snacks or meals);
- → offering coaching to the chemsexers involved (e.g. training opportunities);
- → enabling remote chemsexers to participate via digital tools.

FURTHER INFORMATION:
Guide « Participation des usagers, de l'implication à la coopération », Fédération Addiction, 2019,
AVAILABLE HERE

EFFORTS IN THE PILOT SITES OF PARIS, MONTPELLIER, LYON AND AIX-MARSEILLE

All four pilot sites in Paris, Montpellier, Lyon and Aix-Marseille have decided to set up community activities, using different methods adapted to the needs of chemsexers.

The Paris pilot site has run a series of discussion groups, including a 'Chill'Out' session every Tuesday evening at SPOT for chemsexers who want to continue practising chemsex while reducing the risks. Throughout the year, an expert would often join the group to talk about a specific topic, such as product analysis, injections and dating apps. Later, because of the loyalty and interest shown by the group, this became a follow-up group where chemsexers would come spontaneously, every Tuesday for two hours, with one topic per talk: products, sexuality, freedom of expression and education in harm reduction, mental health and so on.

The pilot site also organised around thirty open information sessions. The drop-in service, staffed by a SPOT counsellor, a nurse and a volunteer at the Checkpoint every Saturday afternoon, offered free advice, appointments and, most importantly, screening. As a result, people supported by SPOT have the opportunity to continue their treatment at the Checkpoint without interruption.
The Montpellier pilot site has reorganised its services. The SPOT was already receiving chemsexers on Thursday afternoons and early evenings. The idea was to make the most of this time with new services, such as the possibility of asking CAARUD Axess to help raise awareness about harm reduction, injection support, drug analysis, etc. The 'Before KéSexcé' sessions, held once at CAARUD and once at AIDES, provide a comprehensive harm reduction package for chemsexers.

The Lyon pilot site introduced two types of community information sessions. The first took place on Friday evenings at the beginning of the month, before the weekend, at the CAARUD Pause Diabolo, for chemsexers who are very active in their use, with the aim of planning and reducing risks (equipment, product analysis, etc.). The second session took place on Saturday afternoons at the end of the month at the AIDES premises, for people who want to reduce or stop using drugs, with the aim of setting up a self-help group. By organising two sessions for chemsexers with different objectives, the aim was to address all profiles and meet their needs.

The Aix-Marseille pilot site has set up self-help groups called "Before chemsex", which meets every second Tuesday of the month for chemsexers who want to reduce their risk, and "After chemsex", which meets every fourth Tuesday of the month for chemsexers who want to interrupt or stop their habit. These sessions, with their different aims and themes, have helped to mobilise and reassure chemsexers about their situation.

PROVIDE A WIDE RANGE OF SUPPORT SERVICES

Professionals work with chemsexers who have different histories, needs and desires, all of which may change over time. The support offered must therefore be adapted to the different stages of a chemsexer's experience and allow for ongoing pathways:

- → prevention before potential problems arise;
- → harm reduction for chemsexers who wish to continue their practice;
- → support for people who want to stop chemsex (abstinence).

TESTIMONIAL

HÉLÈNE DONNADIEU,
Professor and Head of the Addiction Unit at Montpellier University Hospital

The quality of the interaction with a chemsexer and the support he or she needs requires precise knowledge of the sexual health of men who have sex with men (MSM), as well as the 'know-how' needed to ensure that the practice is discussed in a sympathetic and non-stigmatising way.

Expertise in addiction is not the only requirement; it is important to understand and appreciate the place of this practice in an individual's life. Chemsex is the use of specific psychoactive substances for the specific purpose of a sexual encounter involving performance, endurance and disinhibition.

SEX DICTATED BY 'GAY CULTURE', MARKED BY THE HISTORY OF HIV AND THE STIGMATISATION OF HOMOSEXUALITY IN FRANCE

The combination of psychoactive substances, sexuality and geolocation applications makes the equation even more complex. These applications in themselves are highly addictive, maintain the excitement during the sessions and are sometimes the only way for men to meet other than at "parties".

Consequently, these concepts need to be integrated into the support offered and must be welcomed unconditionally, regardless of the person's request ('continue using', 'control' or 'stop using'). There are two ways of looking at the use of psychoactive substances: firstly, their impact on the sexuality of the person concerned, or the consequences of their use: disinhibition, increased

sensory pleasure and/or access to a sexuality previously considered inaccessible (internalised homophobia, traumatic experiences, serophobia, ageism, pain, etc.).

The next stage is the actual use of the substances: method of administration, quantity, rhythm and intensity of use. This is where all the risk and harm reduction skills needed to offer and implement appropriate support come into play. These harm reduction techniques are applied to the use of psychoactive substances (needle exchange programmes, other modes of administration, learning how to inject safely) and to sexual health.

Advice on the use of enemas, lube, toys and STI prevention are all covered under sexual health, but particular attention needs to be paid to the notion of consent itself. As the use of substances compromises consent, it is important to talk openly about experiences of sexual assault and to provide appropriate support. In all these conversations, it is important to use a specific vocabulary, or at least to have a thorough understanding of it. In most cases, however, it is unlikely to be effective to support a chemsexer on your own. Such care requires a clear and accessible network of different practitioners and, of course, structures with a community-based approach'.

GETTING TRAINED, IMPROVING SKILLS AND SHARING BEST PRACTICE

Supporting chemsexers is a specific public health issue that requires a wide range of knowledge and skills:

- → welcoming and supporting LGBTQIA+ groups;
- → sexual health;
- → community health;
- → addiction (including harm reduction, product properties and side effects);
- → mental health, etc.

Having a full range of skills ensures the best possible care for chemsexers. Professional skills can be developed by

- → increasing interaction with chemsexers;
- → sharing best practice with team members, partners and chemsexers themselves;
- → organising awareness-raising events;
- → attending training courses;
- → introducing thematic monitoring.

FURTHER INFORMATION:
Consult the websites of AIDES and the Fédération Addiction or your local Corevih (Coordination régionale de lutte contre le VIH).

TESTIMONIAL

CLÉMENTINE DABONOT ET JULIETTE FORTE,
nurses at the CAARUD Pause Diabolo of the Le Mas association in Lyon

Before joining the ARPA-Chemsex project, we felt powerless in the face of certain problems related to chemsex: lack of familiarity with professional tools designed for this population, fear of speaking inappropriately, lack of knowledge of motivational interviewing, etc.
We also needed to expand our partnership network. This project allowed us to establish a strong link with AIDES in Lyon. Together we've been able to run a number of joint initiatives, including health information sessions and weekends for chemsexers. We can also refer people more easily to the AIDES support group.
Thanks to our activist colleagues, we now feel more comfortable with chemsex issues. The seminar organised as part of the project, which brought together all the staff from the pilot sites, allowed us to take a cross-cutting look at other people's practices and experiences, and strengthened our desire to do more'.

EXPLAINING THE SERVICES OFFERED

It is essential to communicate with chemsexers so that they are aware of the services available to them.

COMMUNICATING WITH PEOPLE

Direct communication with chemsexers must be:

→ clear;
→ non-stigmatising;
→ consistent with the identity of the chemsex community.

Involving chemsexers throughout the design and implementation of the project will facilitate the dissemination of communication tools by word of mouth. It is also important to reach out to chemsexers (and the community structures they attend) and promote the programme directly in their social circles or through contacts on dating apps and websites.

INDIRECT COMMUNICATION WITH PARTNERS

Partners must also be reached: community structures, addiction services, hospitals, medical and social services and LGBTQIA+ social venues (bars, nightclubs, saunas, etc.). It is important to get in touch with the teams and attend local meetings.

'CHEMSEX CLUB' POSTERS

During the ARPA-Chemsex project, several pilot sites mentioned the need for a communication medium to promote local support services for chemsexers.
To meet this need, AIDES and the Fédération Addiction worked on posters to be used by all the pilot sites of the project: 'Chemsex Club'.
The 'Chemsex Club' is a communication tool for chemsexers, in the form of posters and flyers, presenting the multidisciplinary support services offered by the sites:

> on the front: a common message about the multidisciplinary services offered, describing the principles of the project (support and dialogue, sexual health, harm reduction, referral to care and self-help);
> on the back: local services offered by the pilot sites (see examples of posters).

The graphic designer (Mora Prince, atelier C'est signé) created the visuals with the following objectives:

> be consistent with the communications produced by AIDES and be able to appeal to the target audience: chemsexers who are no longer using or who are actively using drugs, and the gay public in general;
> feature both young and older men of different appearances;
> avoid blaming or stigmatising anyone through demeaning attitudes or behaviour.

The posters are displayed in the front windows of reception areas and have been distributed to partner venues (saunas, bars, hospital services, CeGIDD, etc.) and flyers are distributed at all external events.

MONITORING AND EVALUATION OF INITIATIVES

BEFORE THE PROJECT

1

- Set SMART objectives: Specific, Achievable, Realistic and Time-Bound.
- Create a monitoring tool (if you don't already have one)
- Define monitoring indicators according to your own tools (if you have them) or according to the data you use every day.

DURING THE PROJECT

2

- Fill in the action monitoring tool
- Ask the chemsexers questions on a regular basis about their level of satisfaction and the progress they have made in taking charge of their health.
- Set up self-assessment sessions to identify key areas for improvement (during meetings).

AFTER THE PROJECT

3

- Carry out an evaluation of the project (internal or external):
  > Outcome evaluation: the extent to which the objectives have been achieved;
  > Process evaluation: the way the project works.
- If necessary, use the project to document how it was set up and share it with other actors (capitalisation method developed by the Société française de santé publique and the Fédération Promotion Santé).

FURTHER INFORMATION:
The CAPS website
www.capitalisationsante.fr
dedicated to experiential knowledge in health promotion

RECOMMENDATIONS FOR SETTING UP SUPPORT PROJECTS FOR CHEMSEXERS

INVOLVE CHEMSEXERS IN ALL STAGES OF THE PROJECT

—

ENSURE THAT CHEMSEXERS ARE AWARE OF AND FAMILIAR WITH WHAT IS ON OFFER

—

Identify channels and media for direct communication (among chemsexers themselves) and indirect communication (dissemination of information to medical, social and community structures in the area)

SYSTEMATIC COLLECTION OF INFORMATION ON NEEDS AND SATISFACTION

—

Identifying shifts in needs and ongoing evaluation of existing provision

STAFF TRAINING (ABILITY TO PROVIDE SUPPORT)

—

Topics: chemsex, welcoming LGBTQIA+ people

MAINTAIN, STRENGTHEN AND FORMALISE HEALTH REFERRAL PARTNERSHIPS

—

Expanding the regional network to better support chemsexers

INCREASE PROFESSIONAL AWARENESS ('REFERRAL SKILLS')

—

Issues: consent, violence, dealing with psychological trauma, chemical dependency, monitoring products and patterns of use, etc.

PROVIDE SPECIFIC SERVICES FOR CHEMSEXERS WHO ARE CURRENTLY ABSTINENT OR WHO WISH TO ABSTAIN

PROMOTE THE EXCHANGE OF GOOD PRACTICE AND TOOLS

—

Pool resources, get in touch with experimental organisations, join networks of organisations or professionals involved in supporting chemsexers.

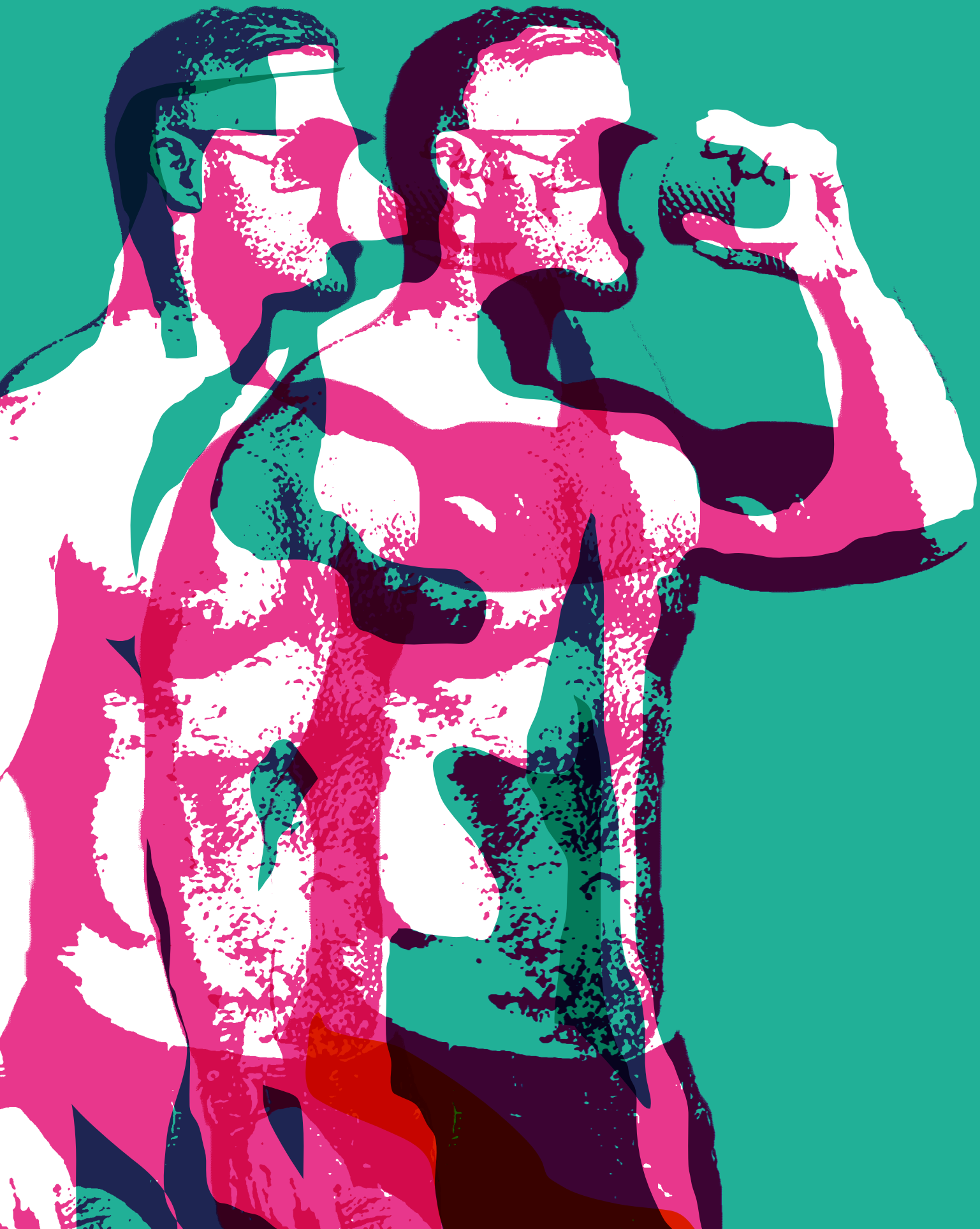
EXPLORE PREVENTATIVE MEASURES TO HELP 'HAPPY CHEMSEXERS'

Raise awareness among 'happy chemsexuals' (active chemsexers with no specific problems related to their practices) through appropriate offers: provision of equipment, dissemination of good practices, organisation of group sessions, etc.

ENSURE ADEQUATE RECEPTION CONDITIONS

—

Thematic presentation, user-friendly facilities, confidentiality



PART 2

A SEXUAL HEALTH APPROACH TAILORED TO CHEMSEX

"MY MUM ASKS ME IF I WANT THE GIRL TOY
OR THE BOY TOY WITH MY HAPPY MEAL.
I WANT THE GIRL TOY.
IT'S A DOLL, I LIKE DOLLS.
MY BROTHER LOOKS AT ME. ...
THE BOY TOY. I WANT THE BOY TOY."

Chemsex-related practices need to be investigated. The answers to these questions cannot be found in sexual prevention or in reducing the risks associated with the use of psychoactive substances, but rather in both areas, which are inextricably linked. Prevention and harm reduction strategies are essential, but they will remain insufficient if they do not adopt a global health perspective. Services must therefore be based on an integrated approach to improving sexual health and quality of life.

WHAT IS SEXUAL HEALTH? THE WHO DEFINITION (WHO (WORLD HEALTH ORGANISATION)

The World Health Organization (WHO) defines sexual health as "a state of physical, emotional, mental and social well-being related to sexuality, and not merely the absence of disease, disorder or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, and the freedom to have safe and pleasurable sexual experiences, free from coercion, discrimination or violence. In order to achieve and maintain good sexual health, the human and sexual rights of every person must be respected, protected and fulfilled." This comprehensive approach to sexuality is both positive and not limited to health issues. Sexual health includes self-esteem, respect for others, pleasure and reproduction.

Sexual health is an integral part of health and well-being, but also of the quality of life as a whole. It is therefore essential for everyone to:

- → have access to good quality information;
- → know more about the risks involved, particularly in the case of unprotected or poorly protected relationships;
- → have access to sexual health services;
- → be able to live in an environment that supports and promotes sexual health.

Sexual health must be considered from the perspective of sexual justice, as defined by the World Association for Sexual Health (WAS).

WAS (WORLD ASSOCIATION FOR SEXUAL HEALTH) DECLARATION ON SEXUAL JUSTICE, ANTALYA (TURKEY), 20 OCTOBER 2023

The World Association for Sexual Health (WAS) proclaims that:

Sexual justice contributes to a more equal and inclusive world and is essential for the achievement of sexual health and rights for all people without discrimination, fear, shame, and stigma.

Sexual justice is a central dimension of social justice, as it relates to sexuality and sexual health and is essential for the respect, protection and fulfilment of sexual rights as human rights.

Sexual justice is fundamental for just societies and addresses the social determinants and structural conditions of inequalities and discriminations that persist globally in relation to sexual health and rights, that particularly impact oppressed, marginalized and discriminated populations. Sexual justice requires a challenge to societal norms, power dynamics and institutions, attitudes and prejudices that perpetuate discrimination and violence in relation to sexuality and sexual health and demands structural changes in societies. The World Association for Sexual Health:

AFFIRMS that Sexual justice encompasses the principles of human dignity, autonomy, bodily integrity, self-determination and citizenship and promotes inclusivity, non-discrimination, and social acceptance of the most underprivileged, marginalized and stigmatized populations – and individuals – in terms of social class, gender, diverse relationship structures, race/ethnicity, migration status, age, health status and disabilities among others and embraces diverse sexual orientations, gender identities and its expressions and bodily diversities.

RECOGNIZES that sexual justice is interconnected with and cannot be achieved without climate and environmental justice, racial justice, health justice, gender justice and economic justice and other facets of justice that constitute the basic pillars of a just society

DECLARES sexual justice addresses the social determinants of health and sexual health and is essential for the achievement of the highest attainable sexual health.

"CHEMSEXUAL HEALTH": A TRIPARTITE DISCUSSION ON GAY SEXUAL HEALTH

ALEXANDRE ASLAN
is a sexologist
and psychotherapist
at the Saint-Louis Hospital in Paris

FRED BLADOU
is a sex therapist with a diploma
in addiction and is the chemsex
referent for AIDES

MATHIAS CHAILLOT
is a journalist specialising
in the subject

They wondered whether gay people suffer from a glaring lack of information and access to sexual health care, and how this affects the practice of chemsex.

MATHIAS CHAILLOT (MC) :
What do you think is the average amount of sexual health information a gay man has received in his lifetime?

FRED BLADOU (FB) :
To make a rather blunt comparison, women never mention pleasure, because the only subject under discussion is reproductive health. In a way, AIDS is our way of getting pregnant: all those questions about how to live your sexuality or your sexual practices properly are never addressed because the only focus is on HIV from the moment you start having sex. They never ask if you know how to take care of yourself, if you know what you like, if you feel comfortable with your sexual orientation or practices.

ALEXANDRE ASLAN (AA) :
The WHO definition of sexual health is much broader than just the absence of disease. In many areas, a health care provider deals with treatment or prevention, but dealing with issues that seem intimate or even personal can feel like a lack of legitimacy. A double bias arises in the case of homosexual sexuality, which belongs to a smaller population with even less familiar codes.
Sexology is complex because it deals with three different aspects: the biological and medical (the body), the psychological (fantasies, individual emotional development) and the emotional (relationships). What is the right way to go about this? Sometimes sexuality reflects social representations, community pressures and what society imposes, overriding the individual voice of each person. However, in certain environments it is more complicated not to present oneself as a great sexual performer; in such cases it is essential to know how to position oneself in relation to all these expectations.

F.B.
Do you ever ask a gay man today how he feels about himself? No. And yet, how many of these gay people tell us that they feel bad about their homosexuality, or that they are victims of extremely high levels of structural homophobia? So the first question would be whether they accept themselves as gay. Then comes the acceptance of the practices, the fact that they know their own tastes, what's exciting for them and what's not, without having to follow systematic orders like penetration or whatever. Many people tell us that they feel disgusted after doing things that don't suit them. It's as if it's compulsory to do certain practices in order to be successful and bankable on apps.

M.C.
So how do you build this common foundation for sexuality education in general and MSM sexuality in particular?

A.A.
As soon as they start seeking care, family doctors, like all health professionals, should have at least the same kind of general knowledge about the main aspects of sexuality as people should be aware of the effects of substances such as cocaine, GHB or 3MMC. In a study carried out at the Saint-Louis hospital, 60% of people who consulted a chemsex practitioner had a problem with their sexuality that they had possibly tried to treat with chemsex practices: erectile dysfunction, ejaculation problems, performance problems, hygiene problems, and so on. However, you might think that if, instead of the porno-chemsex product solution, they had met someone who could inform them or deal with these issues, it might have lowered their expectations of chemsex.
The first challenge is to educate all health professionals, but we also need to address the issue of sex education in schools and social settings. We must not leave it to the Internet, and ultimately to pornography, not to educate, but to invade, through massive representations, what gay sexuality 'should' be.

F.B.
However, if we think that we need to start from an identified pathology in order to deal with a sexual health issue, then we are mistaken. Of course, erectile dysfunction can be pathological, but it is 80% psychological.

Viagra is not going to solve the problem. Our problem is that the issue of sexual health and pleasure among gay men has been completely medicalised or completely ignored, to the detriment of therapy and dialogue. This process of medicalisation has taken place very gradually, following advances in HIV treatment. Even behavioural prevention has been abandoned in favour of medicalised prevention (test and treat, Prep, Tasp, TPE...). We no longer talk, we prescribe.

A.A.
Very often sexologists need to be involved in sex education, because we have to deal with societal expectations imposed by the patient. And this basic information also applies to nurses, because many of them, through lack of training, accept these representations. For example, what is the average size of an erect penis? How long does physiological intercourse last? With chemsex, people think it must last at least two or three hours. And to 'deconstruct' something that has been built up over a long period of time in just a few sessions is quite a job... so it must be approached systematically.

M.C.
A nurse or family doctor is not expected to talk about sexual matters. So why should they talk about it when they see a chemsexer?

F.B.
Because many people are unaware of their sexual practices or simply unable to express or take responsibility for their sexual desires and impulses. In most cases these guys can't explain why they do what they do and why it's so standardised. How can 150 guys all like the same thing? The products play a role, of course, but it's not the drugs that condition the brain to get fisted. There are inevitably other distortions, including the fact that what they think of as their sexual education has been done either on the internet or by reproducing codes or rituals, without imagination, without learning about independent sexuality. It's important that first aid providers are able to break down these prejudices.

A.A.
It's important to emphasise to our caring colleagues that being a man doesn't necessarily make you more competent to care for men, and vice versa. So why should you have to be LGBTQIA+ to care for LGBTQIA+ people? Given the scale of the phenomenon, it cannot be the exclusive responsibility of specialist centres or community care. All centres that treat infectious diseases, STIs or Prep, which care for these patients, could organise themselves to offer sexual health care, including screening for sexual dysfunction, and thus avoid the risks associated with chemsex. It would be a mistake to refuse a patient because you're not familiar with the environment or its practices, and it's better to seek training.

F.B.
As Alexandre has just said, what I find extremely interesting is this networked approach to care: we all have to be specialists. It's crazy that infectious disease specialists don't ask how patients are coping with their sexuality before prescribing antiretrovirals or Prep. For our part, as epidemiologists, mental health professionals and community health workers, we need to consider this issue at all stages. According to recent studies, 13% of gay men have had chemsex in the last 6 months. This means that the practice of chemsex is widespread, so we all need to get on board. Of course, I don't necessarily try to deal with every problem: if a chemsexer has psychotraumatic problems because of childhood abuse, homophobic discrimination in the family or ADHD, then referring them to specialists is the right thing to do, but we need to work together to give patients the best possible advice.

M.C.
But how do I get trained?

A.A.
Scientific information and care days on chemsex, which bring together various medical specialities, are open to all health professionals throughout France. There are also sexology days where we have presented some data from our practices. We also take part in national conferences on psychiatry, addiction and infectious diseases. The aim of all these initiatives is to train and inform our colleagues in other specialties, otherwise we risk losing the overall contact between caregivers and perpetuating the fragmentation of patients. And yet, these patients are already highly fragmented in their sexual experiences, cut into pieces by applications... like one day a penis, another day an anus or a body, and so on. But the desire, the subjectivity, the feeling of connecting these parts is lost. And there is a danger that we all become caretakers of parts for people who are themselves treated as parts.

F.B.
A prerequisite would be to make care workers aware of the issues of gender identity, sexual orientation and drug use. Today we see a large number of care workers struggling to deal with these issues. We need to improve the skills of our colleagues, even if they are not specialists, so that they receive them properly and are not cut off from care, and we need to ask the authorities to include these issues in university curricula.

M.C.
There is still the problem of those who don't come specifically for chemsex counselling...

A.A.
That's why Prep, open discussions, psychology and general medicine offer an opportunity. And quite often the seed of discussion that we plant in their minds at that moment, simply by asking them 'when was the last time you had sexual relations without any products', germinates and they feel more comfortable coming back to talk about it. You could ask the following question: 'Do you have a sexual relationship that you want, that you desire, that you enjoy without any products? They will then start to talk about pre-constructed scenarios from pornography: the dominant-dominated, the fist, group sex... These scenarios sometimes seem to have been put on like armour over something more fragile. Everyone accepts it, internalises it, but in the end realises that it hides something very naked. This 'therapeutic exposure' involves working on emotionality, encounters and intimacy, all elements that patients find difficult to deal with. Because they have so many sexual relationships, you might think that they are familiar with intimacy, but you might also think that, on the contrary, this multiplication of shots prevents them from engaging in intimacy. And our job is to help them deal with all these issues and guide them towards alternatives other than chemsex.

F.B.
In addition, 36% of chemsexers are not engaged in treatment and 30% of HIV-negative chemsexers are not taking Prep, which means they come into treatment too late. It is essential to find ways of engaging them and making them aware of the potential dangers and harms associated with inappropriate use of products or addictive behaviour. Treatment services must be attractive, both in terms of finding equipment in a community setting and in terms of consulting a psychologist. In any case, today too many people start chemsex and deteriorate within two or three years before seeking treatment. So, we need to shorten this period, especially by promoting sexual health. Otherwise, the number of dramatic situations will increase.

M.C.
Good sexual behaviour starts with being able to talk about it. I hope that this discussion will lead to many others, in all the departments concerned. Thank you both very much.

REDUCING RISKY PRACTICES FOR HIV, HEPATITIS AND STI TRANSMISSION

Sexual prevention (or sexual risk reduction) must be adapted to the sexual behaviour and practices of each individual. Public health authorities publish and update regularly recommendations for the most vulnerable specific groups of the population. As there are currently no specific recommendations for chemsexers, we are providing our own, based on the needs and observations expressed by chemsexers themselves and existing epidemiological data.

In every group, in every sexual network, there is a collective viral load, i.e. the amount of HIV/AIDS virus circulating in that group. The prevalence of HIV among MSM is now estimated to be around 7%.[6]

This group is therefore a top priority for innovative prevention strategies. Other studies show a higher prevalence, up to more than 20%, depending on the groups observed.

Chemsex can therefore lead to an increase in risky situations and practices. The number of partners, potentially traumatic BDSM practices (which allow the virus to enter the bloodstream) and the use of injections can increase the risk of transmission. The prevalence of viruses and infections is also high.

HIV CONTAMINATION

Chemsex practices do not encourage systematic condom use. Fortunately, there are other highly effective methods, such as Prep, which can be taken continuously or before each sexual encounter.

HIV screening every 3 months is also recommended for MSM with multiple partners.

HIV-positive people must take treatment (Tasp – treatment as a means of prevention) and achieve an undetectable viral load, which means they can no longer transmit the virus.

→ You also need to be diligent and take your treatment as regularly as possible to ensure that it remains effective.
→ Treatment can be adapted for people with special needs.

HEPATITIS CONTAMINATION

The hepatitis C virus is transmitted sexually or through blood during unprotected sexual intercourse and when injecting or sniffing drugs. The hepatitis C virus is infinitely small and highly resistant in the air. There are tools to protect against it: gloves, disposable injection equipment, etc.

Hepatitis C is easily transmitted and asymptomatic.

→ Screening every 3 months is an important step.
→ If infected, hepatitis C can be treated (the latest treatments are simple, short courses and well tolerated).

Vaccination against hepatitis A and B is recommended for men who have sex with men and should therefore be systematically offered to chemsexers.

FURTHER INFORMATION:
→ https://sante.gouv.fr/soins-et-maladies/maladies/hepatites-virales/

[6] The 2021 results of the Eras survey (Enquête Rapport au Sexe), Santé publique France – ANRS.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

Effective treatments exist for other very common STIs (syphilis, chlamydia, etc.) and are available free of charge.

Again, screening every 3 months is essential, as STIs are sometimes asymptomatic and can be transmitted in a variety of ways, with or without condoms (fellatio, fisting, penetration, etc.).

FURTHER INFORMATION:
→ https://sante.gouv.fr/soins-et-maladies/maladies/infections-sexuellement-transmissibles/article/les-autres-infections-sexuellement-transmissibles-ist

STIGMA AND SECRECY, TWO ALLIES OF TRANSMISSION

Disclosing one's HIV status is never easy and exposes HIV-positive people to criticism, rejection and misunderstanding. Today, too many people do not know their HIV status and would rather not know. This is one of the challenges of prevention for people who have sex with other people: encouraging them to talk about their status, to be informed, to share information and to talk to their partners without fear of rejection.

Informing partners is crucial to breaking the chain of transmission. There are various systems for informing partners anonymously.

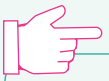
FURTHER INFORMATION:
→ https://www.has-sante.fr/jcms/p_3187510/fr/la-notification-au-x-partenaire-s

LISTENING TO AND CARING FOR OTHERS

Some media and political discourses tend to stigmatise chemsexers. These value judgements are unfounded and damage their self-esteem and ability to protect themselves and alienate them from care. Talking about chemsex is not about promoting products or judging people.

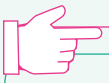
Professionals have a role to play in helping them to reduce the risks associated with their drug use and to look after their quality of life and health.

SPECIFIC RECOMMENDATIONS FOR CHEMSEXERS



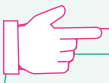
IF YOU ARE **HIV-NEGATIVE**

- → Ask your partner about his or her serological status and protect yourself if he or she is not on treatment or does not know his or her status;
- → Use preventive treatment (Prep);
- → Be tested for HIV, hepatitis and STIs every 3 months;
- → Reduce the risk of HIV, hepatitis and STI infection;
- → Inform your partners of any infection;
- → Inform your partner(s);
- → Consult community health professionals (associations, doctors, community health centres, etc.).



IF YOU ARE **HIV POSITIVE**

- →Take your medication properly, have blood tests and screening (for viral load, STIs and hepatitis) every 3 months;
- → Encourage people to talk about their HIV status and their fears in a supportive and non-judgmental way;
- → Do not overlook other infections that are considered less serious because they could be transmitted to partners;
- → Have an undetectable viral load (Tasp: 'Treatment as Prevention');
- → Contact a community health centre or your family doctor as soon as you have been exposed to an infected person or develop symptoms of an STI, or go for a check-up every 3 months, depending on your practices and the number of sexual partners you have.



AND MORE

- → Adopt a test and treat strategy: systematic screening and immediate treatment without delay;
- → Do not have sexual intercourse (fellation, penetration, etc.) while undergoing STI treatment;
- → Get tested for hepatitis C and treat yourself if you are seropositive. There is now free, highly effective treatment for hepatitis C with few side effects;
- → Find out about interactions between antiretroviral treatments and psychoactive drugs.

CONSENT, SEXUAL VIOLENCE AND DRUG USE

'My brother hit me.
As if making me sad would make me less gay'.

With the advent of chemsex, chemsexers have begun to speak out about the sexual violence they experience at chemsex sex parties. In the wake of the #MeToo movement, this issue was already there but had been completely silenced. Such sexual violence stems from an almost structural homophobia that denies any form of sexual abuse among gays, as if it were enough for two gays to be sexually attracted to each other and have sexual relations.

The drugs used, partly to modify sensations and increase pleasure, can also alter behaviour and make it impossible to give consent.

Complaints are never made because it's impossible to tell the police that you've been raped when you were perfectly willing to go to a gay orgy on illegal psychoactive substances. Fear of the police, fear of being judged, fear of prosecution or fear of homophobic reactions are all barriers to effective treatment for victims of sexual violence.

'And when you're snorting [7], you don't care how other people look at you, they don't look at you anymore'.

TOWARDS A GAY CULTURE OF CONSENT

MATTHIEU FOUCHER,
journalist

When I published my survey 'In search of the gay #MeToo' on the VICE website in September 2020, I used data from the VIRAGE study to break a long-standing taboo: the overexposure of gay and bisexual men to domestic sexual violence and incest, with rates of exposure at least equal to those of women on this issue. What became known as #Me-too gay a few months later confirmed this: many of us entered the sexual world through violence, coercion or fear. Some of us have repressed these traumatic memories. Others have learned to deal with them as best they can. Sometimes we have even accepted them as normal because we have never been given the space to talk about them or to think of them as violence, as most campaigns, productions and representations of incest and childhood sexual violence almost systematically ignore MSM. To this day, we remain very isolated and alone on this issue.

A MARGINALISED APPROACH TO SEXUAL LEARNING

Most of us have learned about sexuality in the complete absence of positive markers and role models. To put it bluntly, none of our parents taught us how to fuck a guy properly, let alone how to get fucked properly.

Until very recently, gay love and sexuality were rarely portrayed in the mainstream media, especially for young people. We have never been taught how to love or fuck properly, or how to share pleasure.

And we have certainly never been encouraged to show tenderness, solidarity or respect between us. So our sexual education has been a hidden and marginal process, mainly through pornography. Although I don't want to stigmatise BDSM or hardcore representations of sexuality, which are legitimate, I know from experience that we sometimes find it hard to separate what belongs to the realm of fantasy and the imaginary world of porn (what happens between us and our computer screens) from what is played out and negotiated face-to-face between two or more people, in bed or on the couch. How many guys have given us a stiff neck by forcing us into a deep-throat that we could have done without? How many guys don't know that brutality in bed has to be voluntary in order to be pleasurable and, above all, that it's something to be discussed?

SEXUAL VIOLENCE BETWEEN GAYS

As young adults and then as adults, we are not spared from sexual violence. Violence is not an exception to our sexuality. Sometimes we reproduce it or even accept it as normal, simply because we have not learned to see it and be aware of it, whether we are the victims or the perpetrators. While relationships 'between men' do not involve the same power relations as relationships between men and women, and deserve their own framework for analysis, it cannot be denied that power relations, violence and breaches of consent also exist between us. Age, gender expression, sexual roles, physical strength, money, insecurity, social race, attractiveness and other factors can all affect our ability to set boundaries and be heard, or to comply with those of others.

The influence of drugs and substances, which we sometimes use to overcome the shame of our sexuality and internalised homophobia, to deal with our traumas, or simply as a source of pleasure, doesn't help. There's no judgement here: many of us feel that sexuality with new partners (or sexuality at all) can only exist through the medium of various substances. Personally, at almost 35, much of my gay sexuality would simply not have existed without alcohol and drugs. And if chemsex is first and foremost a gay phenomenon, it's precisely because it operates in all these different areas, from the very specific stigmatisation of our sexuality (remember that 'enculé' is one of the most common French insults and that, even in 2024, being penetrated as a man is still synonymous with public degradation and a personal problem for many gays) to the traumas we can experience and for which there is virtually no dedicated support. As Professor Alexandre Aslan told me in my survey, there is a particularly high correlation between the problematic use of chemsex among gays and sexual violence suffered in childhood.

The links between substance use and sexual violence are therefore complex: obviously, the use of drugs and alcohol, while disinhibiting and enabling encounters, also makes us less able to set limits for ourselves and our partners, and in turn makes us less attentive to the feelings, desires and consent of others. Without stigmatising the use of drugs, we need to learn how to be more vigilant in this area and to be aware of how they affect our relationship with consent, both in ourselves and in others.

PROMOTING A GAY CULTURE OF CONSENT

Many of the gay men I know are ultimately disgusted by the prevailing machismo, the trivialised verbal violence that MSM use against each other on social networks, and the

constant objectification and brutality of relationships between us.

I think it's high time that gay people started to develop their own culture of respect and consent, based on their own specific experiences and cultures of human relationships. Community agencies urgently need to address the issue of sexual violence, not in a punitive, spectacular or scandalous way, but with a view to education and collective empowerment. All it takes is a bit of imagination: the gay media could perhaps publish more testimonials or articles on the subject, and get doctors, specialists and party organisers to talk about the tools they put in place, for example. Sexual health associations and centres could produce leaflets to share best practice. Gay parties could produce posters using our trademark punchlines to raise awareness among partygoers. Bars, clubs and saunas could train their staff to be more aware of what can happen on the dance floor or at the bar, and to be more sensitive to the vulnerability of certain individuals to drug use.

We gays are perceived as being quite free with our sexuality, or at least we fuck a lot: this is something that many communities often envy us for. For a long time, we were seen as the vanguard of sexual emancipation. So why, three years after #MeTooGay, do initiatives still seem so few and timid? What are we waiting for to finally do something? What if, instead of lagging behind, gays could (re)become a model of free, joyful, uninhibited and, above all, egalitarian and consensual sexuality?

'I can't be alone any more, alone with myself, alone with my faults. Alone, so alone that I try to be with other guys who are alone'.

[7] In the language of product consumers, tapping means sniffing products.

RECOMMENDATIONS FOR DEALING MORE EFFECTIVELY WITH ISSUES OF SEXUAL VIOLENCE AND CONSENT

Be there to listen, accompany and support the chemsexer: without judgement, without minimising the traumatic episode

Refer to the courts or the police, depending on the needs of the individual and the situation

In addition to sexual violence, special attention should be paid to vulnerable groups (young users, trans people, racialised people (exoticization), people in precarious situations, sex workers, etc.). It is not uncommon for violence to be reproduced within the community

Make all chemsexers aware of the issue of consent. In a sex party, a person who has used substances must be able to give an explicit yes or no

Train and strengthen the skills of chemsexers (knowing how to talk and listen, how to help others, and failing to help a person in danger)

Develop training to combat sexual violence against MSM

PART 3

ADAPTING DRUG HARM REDUCTION TO THE SPECIFICITIES OF CHEMSEX

"I'VE SEEN GUYS DOING G-HOLES[8] AND WE'D JUST ACT AS IF NOTHING HAD HAPPENED..."

Establishing multidisciplinary support for chemsexers means offering them drug-related harm reduction strategies, which need to be tailored to the specific characteristics of chemsex, i.e. the use of psychoactive substances in a sexual context.

In summary, harm reduction is a public health policy that aims to limit the medical, psychological and social risks and harms caused by drug use, both licit and illicit, to individuals, their communities and society as a whole. It enables us to develop safer drug use practices that take into account the desires and abilities of each individual. It is an ethic of intervention based on the values of benevolence and non-judgement.

[8] Definition on page 31

Ressource : Guide " Réduire les risques : éthique, posture et pratiques ", Fédération Addiction, 2017, 78p, available sur www.federationaddiction.fr

IMPROVING CHEMSEXERS' INFORMATION ABOUT PSYCHOACTIVE PRODUCTS

Implementing a harm reduction strategy requires us to work with chemsexers to develop their knowledge about the products they use, their dosage, patterns of use, desired effects and unwanted side-effects.

Some chemsexers simply enjoy taking drugs occasionally, with no immediate real danger. For others, however, excessive or frequent use can become a problem, leading to social, occupational and health complications.

Therefore, all users need to be able to find appropriate solutions for their own practices.

PRODUCTS AND DOSAGE

"3MMC. It's like coke, but... it's different."

DIFFERENT PRODUCTS MAY BE USED IN CHEMSEX SESSIONS, SOMETIMES IN COMBINATION:

→ Stimulants are mostly used to feel **disinhibited**, excited, to experience a certain sense of achievement, to break sexual taboos and to overcome exhaustion. Certain substances stimulate the desire for unlimited sex. Most of these are synthetic cathinones or new synthetic substances (NPS), which were introduced to the European market in the 2000s. In powder or crystal form, they include a variety of substances such as mephedrone or 4-mmc (4-methylmethcathinone), 3mm-c, 4-mec and others. Cocaine is also commonly used;

→ **GHB** and **GBL** are very common depressants used in chemsex. GHB is a drug used as an anaesthetic, sold as a white crystalline powder or in liquid form for drinking. GBL is a highly acidic chemical widely used in industry, particularly as a paint solvent/stripper. Once ingested, it is metabolised in the body, mainly to GHB, but also to some extent to GBL and succinic acid. This explains the identical effects of the two products;

→ **Crystal methamphetamine** (known as 'Tina'), a super stimulant that can take the form of fine crystals and has very powerful effects;

→ **Ketamine** is a drug classified as a narcotic, used in human and veterinary medicine as an anaesthetic and analgesic. However, it is often abused as a psychoactive product. It is usually in the form of a crystalline powder, usually snorted, but sometimes injected.

→ Other non-addictive products such as erectile stimulants, poppers, etc. may be used and should therefore be considered.

Each substance has its own characteristics and must be dosed and controlled in terms of quantity and number of doses, depending on the individual's state of health, the context and the quality of the product.

CONSUMPTION PATTERNS

THERE ARE DIFFERENT WAYS OF CONSUMING THESE PRODUCTS:

- → **Oral intake**, which is the most common form of consumption. Products in solid crystal form (synthetic cathinones, crystal methamphetamine) can be 'parachuted', i.e. wrapped in a cigarette paper pellet and swallowed directly. GHB/GBL can also be taken in liquid form, diluted in a drink;
- → **Snorting**, i.e. sucking psychoactive substances, usually in powder form, through the nostrils using a straw (synthetic cathinones, crystal methamphetamine, cocaine, etc.);
- → **Inhalation** involves inhaling a volatile or gaseous product (poppers), vapour or smoke from a heated product (smoked methamphetamine crystals or 'tina'). This method is much less common among chemsexers;
- → **Plugging** or **booty-bumping**, where the chemsexer injects diluted substances anally using a needleless syringe or enema bulb (synthetic cathinones, methamphetamine crystals);
- → **Slam**: intravenous or even intramuscular injection of products using a syringe (synthetic cathinones).

DESIRABLE AND UNDESIRABLE EFFECTS AND/OR RISKS

THE MAIN EFFECTS SOUGHT IN THE PRACTICE OF CHEMSEX INCLUDE:

- → Disinhibition, letting go, relaxation;
- → Sexual performance, arousal, stimulation, increased desire;
- → Empathy, euphoria.

PRODUCTS AND THE WAY THEY ARE USED CAN HAVE ADVERSE EFFECTS OR RISKS, SOME OF WHICH CAN LEAD TO SERIOUS PROBLEMS:

- → **Significant effects on energy**, sleep, nutrition, hydration, concentration;
- → **Occurrence of sexually transmitted infections (STIs), viral hepatitis and even HIV**, not to mention haematomas and abscesses associated with the use of slam (injection);
- → Anal (plug, fist) and nasal (snorting) **injuries and bleeding;**
- → **Erectile dysfunction**;
- → **Major somatic complications** in the liver and kidneys, heart and respiratory system;
- → **Nausea, vomiting, dizziness, hallucinations, loss of consciousness and disorientation** due to overdose;
- → **Intoxication by overdose** (called G-hole, K-hole in the case of GHB/GBL or ketamine use), which can lead to coma or even death;
- → **Tolerance** or habituation to the effects of the product, which may lead to increased amounts, frequency and/or intensity of use;
- → **Development of craving** (the irresistible urge to use again);
- → **Psycho-behavioural disturbances**: panic attacks, mental depression, hallucinations and delusions, including suicidal thoughts (especially in the case of crystal methamphetamine);
- → **Significant impact on social life**: loss of self-confidence and self-esteem, loneliness and isolation, disruption of social, friendship and family relationships, but also loss of money and impact on working life (absenteeism, sick leave, loss of productivity, etc.);
- → **Significant impact on sexuality**: risk of sexual abuse and violence, inability to have sex without products;
- → **Development of addictive behaviour**.

INITIATIVES IN THE BORDEAUX AND LYON PILOT SITES

The Bordeaux pilot site produced and distributed prevention and harm reduction videos focusing on the use of GHB/GBL. The videos aim to inform people about the drug and its effects, to teach them how to identify the risks and a G-hole, and to provide good practices in dealing with a G-hole.

THREE AWARENESS-RAISING VIDEOS HAVE BEEN PRODUCED:

1. What is G?'
2. 'What is a G overdose?'
3. 'What to do in case of a G overdose?'

THIS PROJECT HAS TWO MAIN OBJECTIVES:

→ To avoid/limit cases of GHB/GBL overdose.

→ To establish links with primary care providers. Dissemination of these videos is a lever for chemsexers, primary care partners and facility teams.

IF YOU WOULD LIKE TO MAKE VIDEOS ON THIS OR ANY OTHER TOPIC:

→ Choose a short format (between 1 and 2 minutes)

→ Set up a working group to develop the content

→ Set a budget (in this case 15,000 euros was needed) for design and production.

Copies are available on the Fédération Addiction and AIDES websites.

The Lyon pilot site produced three clips on chemsex prevention and risk reduction, entitled "Parlons chemsex" (Let's talk about chemsex), based on the chemsex exchange groups run by AIDES Lyon.

These videos are about one minute long. They explain how best to manage drug use in order to reduce the risks (associated with injecting, sniffing, etc.) and present the support services available.

TO WATCH THE VIDEOS
http://www.youtube.com/@AboutChems

LEARNING HOW PRODUCTS INTERACT WITH EACH OTHER AND WITH TREATMENTS

It's important to understand the interactions between the products you use and any medical treatments you may be taking. The following (non-exhaustive) resources are available to help you do this:

→ Brochures from the Action Traitements association, in particular the drug interaction guide, available at www.actions-traitements.org/reglette and as a free application for smartphones.

→ Table of interactions between the most commonly used psychoactive substances, taken from *Psychédéliques: manuel de réduction des risques,* Société psychédélique française, 2022, available as an annex to this guide: https://societepsychedelique.fr/assets/SPF-Psychedeliques-Manuel-de-Reduction-des-Risques.pdf (p. 40-41).

RECALLING THE LEGAL FRAMEWORK FOR DRUG USE

'Addiction is therefore the only criminal disease'

It may be useful to remind chemsexers that the possession, use and transfer (even for free) of illegal psychoactive substances is prohibited by law. Buying over the internet or using in a private circle will not protect you from possible prosecution. The legal framework also includes article L. 3411-8.-I. of the law of 26 January 2016 on the modernisation of the French health system, which defines the objectives of a harm reduction policy for drug users. According to this article, this policy aims to "prevent the health, psychological and social damage, the transmission of infections and overdose mortality associated with the use of psychoactive substances or substances classified as narcotics"[9].

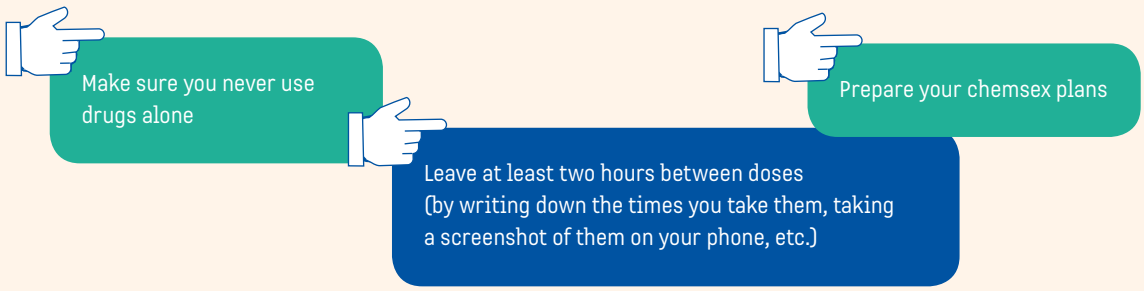
[9] https://www.legifrance.gouv.fr/jorf/article_jo/JORFARTI000031913098

MANAGING CONSUMPTION

The aim of controlled consumption is to set a framework, a limit that must not be exceeded in order to reduce harmful effects. This involves defining the maximum number of plans per month, the quantity of drugs consumed and the duration of the plans, including periods of recovery and breaks from consumption.

In fact, all psychoactive products can have harmful effects on health. The products used in chemsex are often addictive, triggering an irrepressible urge to try them again and again. As a result, chemsexers tend to use far more than is necessary to achieve the desired effects. Overuse can lead to serious harm, including overdose. See risks above.

RECOMMENDATIONS FOR CHEMSEXERS



Check that you and your partners have given your consent before taking any drugs: any sexual intercourse must be clearly consensual a nd expressed by a 'yes' or 'no', which should not be discussed

Use the harm reduction equipment available in community and drug facilities and through the remote harm reduction system: tap cards, straw rolls, disposable syringes, and so on

Stay hydrated and take breaks

Limit the number of products you use in a limited period of time

Avoid mixing products

Leave as much time as possible between chemsex sessions

Call the emergency medical services (15) or the fire brigade (18) if one of your partners feels weak or unwell.
Abandoning a partner in difficulty is an offence under French law, punishable as failure to assist a person in danger.

FURTHER INFORMATION (NON-EXHAUSTIVE LIST)

→ www.aides.org/chemsex
→ www.technoplus.org
→ Vidéos du média KEPS
→ www.psychoactif.org
→ www.psychonaut.fr
→ AIDES Info chemsex

ADAPTING PATTERNS OF USE AND LEARNING HARM REDUCTION TIPS FOR EACH PATTERN OF USE

Chemsex involves different consumption techniques: snorting, inhaling, injecting, anal plugs and parachutes. It is important to inform and support chemsexers on how to reduce the risks associated with each technique and how to adapt their consumption patterns.

The risks vary greatly depending on the method of use. Injection can involve infectious and bacteriological risks and damage to the venous network. It can also accelerate the development of addiction and increase the risk of contamination. To reduce risk, we strongly recommend the use of alternative methods of consumption, such as anal plugs, which carry less risk for similar effects. While some methods of use are more risky than others, it is important to be aware of the best practices for each, as well as the tools available for their use. This applies to dosage, hygiene, filtration and all the gestures associated with each particular consumption method.

REDUCING THE RISKS OF INJECTION

Injecting (or 'slamming' in the context of chemsex) is a practice that carries several risks: damage to the venous network, transmission of HIV and hepatitis, addiction. What's more, the substances used are abrasive.

It is therefore essential to know how to prepare an injection. For this reason, in addition to the information that can be reminded to chemsexers, it may be useful to make available the following resources: for example, the Guide to safer injecting published by Savoir+Risquer, which can be downloaded, or CATIE's Sharp shooters - Harm reduction info for safer injection drug use.

VIDEOS AVAILABLE ON THE AIDES WEBSITE
→ https://www.aides.org/chemsex.

GUIDE TO SAFER INJECTING, AVAILABLE AT
→ https://savoirplus-risquermoins.net

SHARP SHOOTERS - HARM REDUCTION INFO FOR SAFER INJECTION DRUG USE, AVAILABLE AT
→ www.catie.ca

INJECTION SUPPORT

Injection support is a means of monitoring drug use practices that has been integrated into harm reduction initiatives since the Health Act 2016. Injection support is a harm reduction tool that involves taking people who inject drugs step by step through their injecting practices, addressing issues of practice and risk, but also the expertise and attitudes of the drug user.

Injecting support allows work to be done on the practices themselves (hygiene, equipment, injection points, post-injection management, etc.). It also provides time to discuss use. This type of support is particularly relevant when it comes to injecting synthetic cathinones, as these products can cause health damage if injected unsafely. It can be preceded by a pre-injection interview, especially for first-time injectors, and followed by a post-injection debriefing.

As part of the Accompagnement et éducation aux risques liés à l'injection (Aerli) experiment, a partnership between INSERM, AIDES and Médecins du Monde has formalised an injection support protocol. The protocol consists of two main stages: first, one or two trained health workers directly observe a person injecting a psychoactive substance that he or she usually consumes, using a standardised list (observation grid) to document the person's practice and the risks identified. Secondly, an informative discussion between the counsellor and the person concerned after the injection has taken place.

Several organisations working in the field of harm reduction offer Aerli training courses, including the Fédération Addiction and AIDES.

CHEMSEX: PRACTICES AND PRODUCTS CALLING FOR SCREENING FOR SOMATIC COMPLICATIONS AND THE INTRODUCTION OF HARM REDUCTION TOOLS

PR GILLES PIALOUX,

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Vice-President of the Société française de lutte contre le sida – French Society for the Fight against Sida (SFLS) and member of the AFEF-Société française d'hépatologie.

MOLECULES AND SOMATIC RISKS

The screening of complications associated with the various classes of new synthetic drugs (NDS) requires several inputs:

→ Knowledge of the specific side effects of the different classes of new synthetic drugs (NDS). For example: risk of overdose (G-hole) with impaired consciousness, impaired speech, dizziness and vomiting, which may even lead to coma, convulsions, cardiac arrhythmias, respiratory arrhythmias, thermoregulatory disorders (GHB/GBL); renal failure, hyponatraemia, rhabdomyolysis, convulsions, etc. (cathinones); heart failure (cathinones); arrhythmias, chest pain, hypertension, cardiomyopathy due to direct myocardial remodelling or indirect cardiotoxicity, haemorrhagic stroke or vasospasm (methamphetamine), etc.

→ Identification of users' actual drug use. Many harm reduction tools are or will be available for this purpose, such as hair or body hair dosage (Chas 1999), drug analysis or analysis of pharmacovigilance data (Batisse 2021, Cherki 2024, TEDI). These tests are carried out by various associations, such as Analyse ton prod' Ile-de-France (ATPidf), a member of the Analyse ton prod' network, which, in conjunction with AIDES SPOT in Paris, analyses, among other things, products consumed by chemsexers. A composite harm reduction offer combining specific application + testing + hair dosage is underway in a sub-study of the Prep Prevenir-ANRS.MIE study (C. Protiere, G. Pialoux).

→ Understanding the main interactions between drugs (antiretrovirals, psychotropic drugs, erectile stimulants, anti-HCV drugs, anticonvulsants, etc.) and NDS. Several applications are available and/or in the process of being adapted for chemsex workers and users: https://www.hiv-druginteractions.org/, www.clinicalcasesDDI.com, https://mixtures.info/

UNDERSTAND THE RECOMMENDATIONS FOR THE PRACTICE OF SLAMMING

(cf. Chemsex : livret d'information pour les professionnels et intervenants de santé [Chemsex: information booklet for health professionals and practitioners], Respadd, September 2016).

→ Choose the arm as the injection site;
→ Wash hands and forearms with soap;
→ Clean the injection site in a single pass with a chlorhexidine wipe;
→ Filter the product to be injected until the solution is as clear as possible;
→ Inject into a vein with the needle always pointing towards the heart;
→ Compress the injection site with a dry cloth;
→ Do not share and, if possible, do not reuse the syringe and small equipment (filter, cup, water, etc.). The syringe should be disposed of in a special container or, if not available, in a can, which should then be folded;
→ Low-risk injection is a technique that can be learned and improved and can effectively reduce the risk of infection. The same approach can be used in centres treating HIV-positive chemsexers or Prep users, based on the Aerli model, with the help of an artificial injection arm. Patients could also be referred to CAARUDs for specific harm reduction advice, particularly on injecting.

REDUCING THE RISKS OF SNORTING

There is a risk of infection when people share straws for sniffing. Disposable straws, which are available from many clubs and facilities, should be preferred. As with other methods of use, you need to crush the product thoroughly, clean your nose with clean water and salt solution, and be careful about how much you take and for how long.

TAKING PRODUCTS IN THE FORM OF A PARACHUTE OR ANAL PLUG

The parachute consists of wrapping a quantity of the product in cigarette paper and swallowing it. The anal plug consists of diluting a quantity of the product in water and inserting it anally using a syringe (without a needle). However, different doses are required for each method.

FURTHER INFORMATION
→ https://www.aides.org/sites/default/files/Aides/bloc_telechargement/absorption_rectale.pdf

PROVISION AND DISTRIBUTION OF SUFFICIENT FREE HARM REDUCTION EQUIPMENT

Sterile, disposable equipment for the use of psychoactive products must be made available:

WHEN
SLAM (INJECTING)

→ 1cc crimped syringes
→ Sterifilt
→ Stericup
→ Clip tourniquet
→ Water for injection (WFI)
→ Infectious Healthcare Waste (IHW) collector (container capacity adapted to consumption)
→ Alcohol or chlorexidine wipes

WHEN USING
GHB/GBL

→ Dosing devices
→ 1cc or 2 cc syringes depending on consumption

DURING
SEXUAL ACTS

→ Lubricant
→ Condom
→ Gloves
→ Prep pillbox

WHEN
SNORTING

→ Roll your straw
→ Saline solution
→ Plastic card to crush the product

FURTHER INFORMATION
→ Brochure and vidéo « Les indispensables pour un plan Chemsex en toute sécurité, AIDES »

INITIATIVES IN THE BORDEAUX PILOT SITE

The Bordeaux pilot site designed a harm reduction box for chemsexers, which was then distributed to local family doctors who prescribe Prep.

The box contains all the necessary harm reduction materials: a typing card, a roll-your-straw, condoms, lubricant gels, hydration sachets (not regulated) and a flyer.

The pack was distributed by the Coordination Régionale Addictions (Coreadd), an association that works with health and addiction professionals in the New Aquitaine region.

In addition to facilitating the dissemination of harm reduction materials, the production and distribution of this kit proved useful in several other ways:

- → it enables patients and doctors to talk and exchange ideas more easily;
- → it helps to raise general practitioners' awareness of chemsex and harm reduction;
- → it also strengthens the services available to chemsexers in the local network.

OFFERING DRUG CHECKING

The product a customer buys can often be different from the one he or she actually uses. The best way to find out what a product is made of is to have it analysed. Offering a drug checking service to chemsexers is therefore a particularly appropriate harm reduction strategy.

Drug analysis is a harm reduction tool that involves analysing the contents of products provided by a person who is about to use them (or who has used them), at their request, in order to inform them about the composition of the product. This tool strengthens drug users' freedom of choice by providing them with reliable information about the composition of the products they consume.

For harm reduction workers, drug checking helps to improve knowledge of drug use practices and the composition of products circulating in a given area, and to better respond to the needs of drug users.
Since the 2016 law on the modernisation of our health system, drug analysis is part of the range of harm reduction tools, along with support and education to reduce the risks associated with injecting (Aerli), screening, distribution of sterile equipment, naloxone, etc.
Any structure with a harm reduction mission (CSAPA, CAARUD, self-help associations, associations or groups working in a party environment, community health associations) can provide drug analysis. In France, most of the associations offering drug analysis as a harm reduction tool are part of the "Analyse ton prod" network run by the Fédération Addiction. In practice, drug samples are taken by 'collection' organisations after an interview with the person concerned. The sample is analysed on the spot, if the organisation has an analysis laboratory, or sent to a partner laboratory. All these professionals have specific training.

Depending on the technique used, the result is available in a few hours or a few days and can be more or less precise about the proportions of the various components in the sample. During a second meeting, the results are presented, and the composition of the product and any health risks are discussed.

This type of product analysis must be distinguished from the analysis of drugs offered by the SINTES system of the French Observatory of Drugs and Addictive Tendencies (OFDT), namely the analysis of drugs for health monitoring purposes ("surveillance and alert on products in circulation and their health risks").

TESTIMONIAL

AURÉLIE LAZES-CHARMETANT,

project manager at CEID-Addictions (pilot site for the ARPA-Chemsex project in Bordeaux and focal point for AIDES) and coordinator of the SINTES system for OFDT

"Drug analysis for harm reduction purposes and any associated support for use are practices that should be included in the package of harm reduction tools available to people practising chemsex. The substances commonly used in chemsex are GBL (which is metabolised by the human body to GHB when ingested), Tina (methamphetamine), cocaine, ketamine and, in most cases, substituted cathinones (3MMC, 2MMC, 3CMC, etc.). This list is constantly evolving over time. Drug analysis helps to identify the exact molecule consumed. The market for substituted cathinones is highly volatile, with frequent substitution of one molecule for another due to legal bans and supply shortages.

Drug analysis also reduces the risk of overdose. By knowing the components and/or concentrations of the drug, users can adjust doses and avoid accidental overdose.

Most substances contain several molecules (synthetic residues, diluents, excipients, agglomerants, etc.), which analysis can help to identify in order to avoid the use of some of these compounds. It is recommended to combine drug analysis with unrestricted access to low-risk consumption devices.

Analysis results can be used to inform and empower users about the specific risks associated with the substances they use, or the interactions between different molecules and/or drug treatments.

Analyses can be carried out directly in the centres that provide the service, sometimes in the context of a party, and also by sending analyses by post.

Harm reduction analysis laboratories are linked to the OFDT's SINTES national surveillance system and participate in national and European health surveillance.

Harm reduction drug checking is an essential strategy for minimising the harmful effects of chemsex. By providing accurate information on the composition of substances and raising users' awareness, it is possible to prevent overdoses, infections and other health risks, while offering support and validated information to chemsexers."

INITIATIVES IN THE LYON PILOT SITE

In Lyon, as part of the ARPA-Chemsex project, the pilot site offers twice-weekly consultations where chemsexers can have their products analysed (the CAARUD Pause Diabolo has an analysis laboratory):

→ Friday sessions, chemsexers can receive harm reduction advice to help them prepare their weekend plans;
→ Saturday sessions allow chemsexers to share their experiences, particularly in terms of harm reduction, with a view to taking a break from drug use.

These regular sessions have many advantages:
→ development of greater mutual acquaintance between facilities;
→ retention and follow-up of chemsexers, thus creating a social link;
→ developing product analysis among chemsexers.

CAARUD Pause Diabolo is part of the "Analyse ton prod" network and offers product analysis to around twenty local structures, i.e. more than a hundred collectors. The partnership between these two associations is all the more important as the AIDES mobilisation centre is home to most of the region's chemsexers.

The website of the **'Analyse ton prod'** network, www.analysetonprod.fr, brings together information and resources on drug analysis. This includes a map of all collection and analysis points (both fixed and remote).

REACHING OUT TO CHEMSEXERS

The 'outreach' approach refers both to the movement of professionals leaving the confines of their institutions or traditional areas of intervention to go out and meet people where they live, where they have sexual relations, on the internet (dating applications and other sites dedicated to chemsex), and to openness to other people in their entirety and without judgement. According to some studies, around 30% of chemsexers make very little use of health services or harm reduction services. Reaching out to them is essential to drastically reduce the number of isolated people. 'Reaching out' also means taking into account the specific characteristics of each individual: working hours, geographical location, living conditions, psychosocial context, habits, language spoken or understood. Understanding motivations and context is also essential for reaching isolated groups.

Consequently, reaching chemsexers can involve a variety of activities: setting up an information and prevention stand in festive and LGBTQIA+ environments, analysing products in festive and LGBTQIA+ environments or even in a private context, visiting places where sex is consumed and/or where people meet (bars, saunas, sex clubs, discos, etc.), proposing innovative initiatives ("harm reduction 2.0"), etc. The aim is to reach chemsexers who are geographically isolated and/or relatively unfamiliar with these venues.

All brochures and videos can be downloaded free of charge from the AIDES website:

→ https://www.aides.org/chemsex

DISTANCE HARM REDUCTION, A SERVICE WELL SUITED TO CHEMSEXERS

CATHERINE DUPLESSY,
Director of SAFE

To give chemsexers easy access to the equipment they need for their practice, in quantities that suit their needs, you can refer them to the teams in the national 'Distance harm reduction' network.

The network aims to facilitate access to harm reduction by removing the main barriers: geographical distance, cost of equipment, fear of stigma and concerns about confidentiality.

We provide telephone, video and email support for drug use and sexual practices. We send appropriate prevention tools (injection, sniffing, nasal spray, inhalation, plug, fist, etc.) by parcel post. We also provide access to screening kits, naloxone and a drug analysis system.

Chemsexers also benefit from training on how to inject and access to a nurse who specialises in managing wounds and post-injection complications.

With distance harm reduction, prevention comes straight to your home, and it's free.

FURTHER INFORMATION
→ www.rdr-a-distance.info
→ contact@safe.asso.fr
→ tél.: 01 40 09 04 45

NB (Fédération Addiction and AIDES). Remote harm reduction services provide undeniable added value for people who are isolated from facilities. However, it cannot replace regular meetings (every three months).

AIDES REMOTE CHEMSEX COUNSELLING AND SUPPORT SERVICE

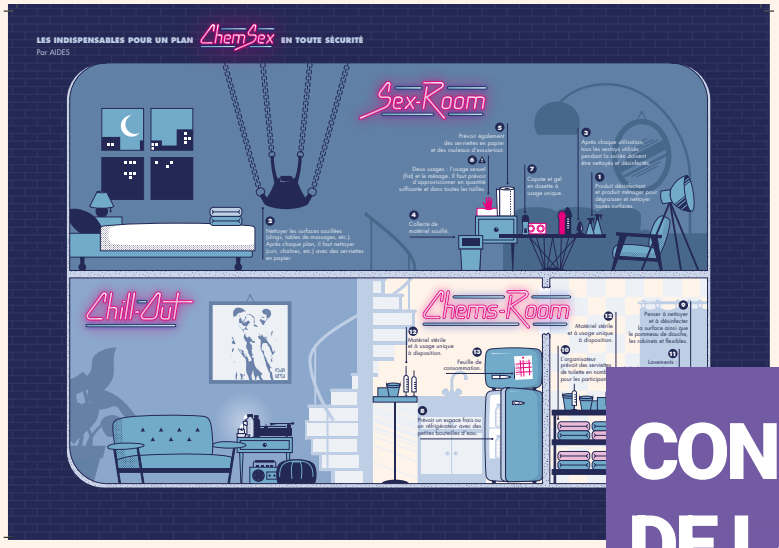
Chemsexers face a double stigma: that of their sexual orientation and that of their use of illegal substances. Some need to remain anonymous because they cannot talk openly about their sexual orientation or their sexual and drug use practices. Many find it difficult to physically go to community sexual health centres (which are too often labelled as places for 'gays') or harm reduction centres (which are too often labelled as places for 'drug addicts'). In addition, many chemsexers are socially and geographically isolated.

To meet these needs, AIDES has set up DES-chemsex (Distance Listening and Support Service), which is anonymous, free and accessible from any smartphone. It provides a safe framework for dealing with people's questions and difficulties. DES-chemsex is aimed primarily at drug users, but also at their families and professionals working in the field of prevention, harm reduction and addiction. More specifically, DES-chemsex is designed to deal with situations that require rapid treatment: overdose, overconsumption, physical or psychological ill-health (bad trips, anxiety, descent), HIV or hepatitis risk, behavioural changes and modifications, feelings of isolation, interactions between psychoactive products and HIV treatment, the harmful consequences of drug use on health and the family, social and professional environment, etc.

DES-chemsex consists of four complementary tools:

- → An anonymous offer via the WhatsApp application: 07 62 93 22 29
- → A Facebook page dedicated to chemsex: Info Chemsex (by AIDES)
- → A Telegram community information and self-help group on chemsex.
- → A chillout video chat group for teetotalers

Remote assistance and support systems are an undeniable asset for people who are excluded from mainstream structures. However, it is important that they still have access to face-to-face services that cover all their needs (access to prep, full STI screening, Aerli sessions, etc.).



"THE ESSENTIALS FOR A SAFE CHEMSEX PLAN"
→ available here [10]

"TAKING DRUGS WITH YOUR ASS"
→ disponible ici/available here [11]

"GHB-GBL" → available here [12]
"CATHINONES, 3MMC, ETC." → available here [13]
"TINA" → available here [14]

[10] https://www.calameo.com/aides/read/006225500a42a19c-0f676?page=1
[11] https://www.aides.org/sites/default/files/Aides/bloc_te-lechargement/absorption_rectale.pdf
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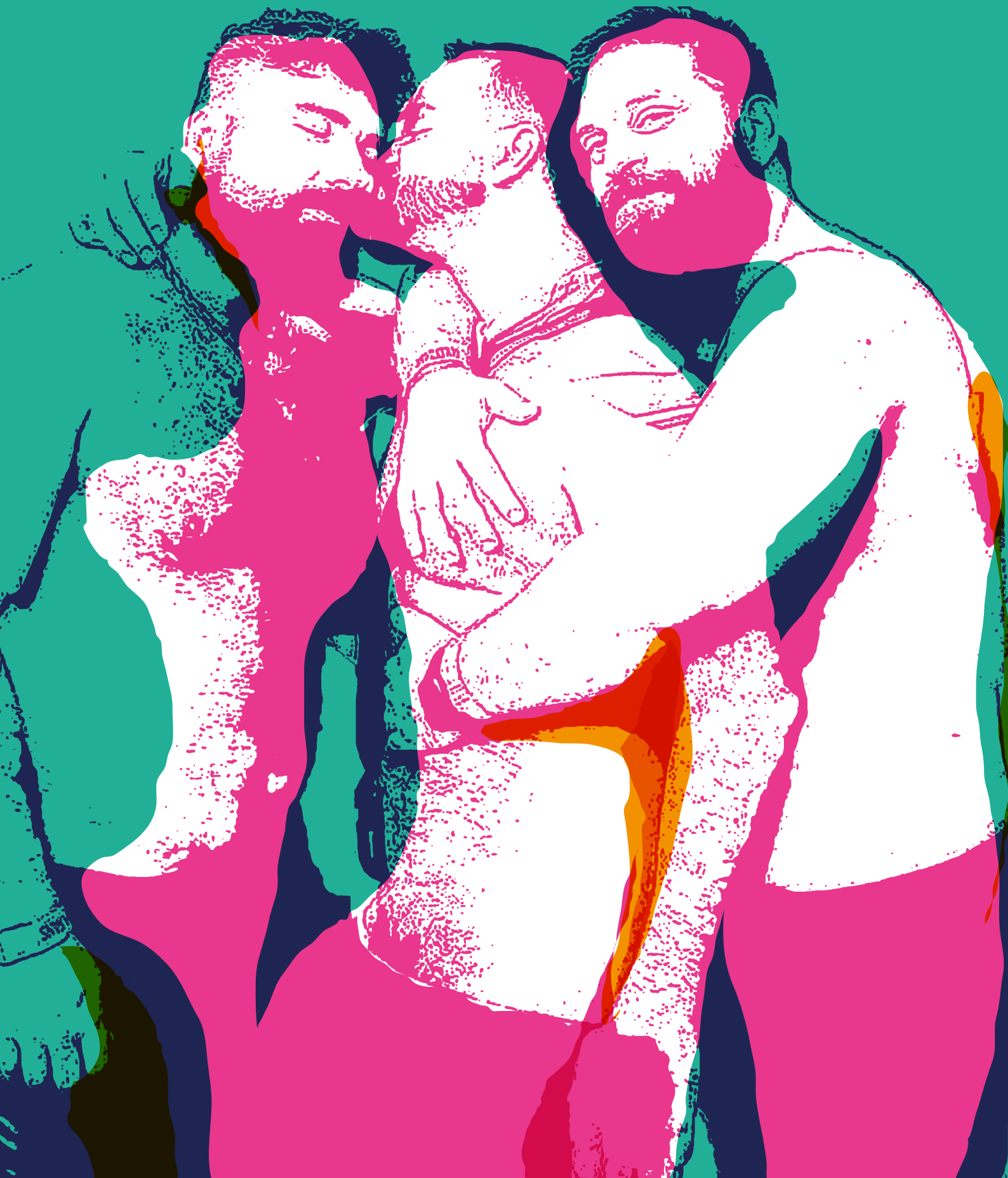


PART 4

CARING FOR THE MENTAL HEALTH OF CHEMSEXERS

MAN, WE EACH HAVE OUR OWN LIFE, OUR OWN SHADOWS AND LIGHTS, OUR OWN DEEP SORROWS, OUR OWN WRINKLES, OUR OWN FAVOURITE ANTI-ANXIETY DRUGS, OUR OWN DRUGS, OUR OWN DISAPPOINTED AND DESTRUCTIVE ROMANCES. EVERYONE HAS A DIFFERENT RHYTHM OF GRIEF

Focusing on the mental health of chemsex addicts with a view to improving their overall health and quality of life is one of the most important aspects of the multidisciplinary services described in this guide.

Harm reduction practitioners have long and rightly rejected any form of systematic psychiatric treatment of drug users. Tensions have existed for years between harm reduction advocates and certain psychiatric and addiction professionals. Conflicts have centred on access to substitution treatment, needle exchange programmes, calls for cessation and permanent abstinence, and the use of heavy and inappropriate medication, which fails to recognise the socio-psychological consequences for the individual. Under the law, which penalised drug use, it was imperative for users to seek treatment in order to comply with prohibition and morality, to the detriment of any personal consideration of their history, past and traumas.

Today, this division has almost completely disappeared. ARPA-Chemsex is a good example of this paradigm shift in the way the mental health of chemsexers is treated.

NEW CONSUMER DEMANDS AND DIFFERENT CLINICAL EVIDENCE

WITHIN THE ARPA-CHEMSEX PROJECT:

→ Very early on, we heard widespread and repeated requests for help from users in difficulty who were completely unable to control, reduce or manage their use (whether of sex or products). They often expressed depression, an inability to cope with cravings, problems in their marital relationship or, more generally, a deterioration in their emotional life, an inability to work ("job loss") or to fit into a "normal" rhythm of life that would encourage them to pursue a professional activity or even to engage in sporting or social activities. The number of people expressing these more or less serious difficulties has led us to think about community self-help and discussion groups. These groups can have a number of positive effects (resocialisation, talking about oneself among peers, without judgement, among gay men who experience more or less similar sexual activities and use community psychoactive products). Although this approach produces convincing and positive results, it does not resolve all situations.

→ The repetitive nature and frequency of the self-help groups set up by the pilot sites meant that users could not be kept busy several evenings a week, and they could be too repetitive, stressful and intrusive for the facilitators, who were trained in a wide range of interview techniques, including motivational interviewing. As a result, we began to think about new partnerships to improve early referrals for the most vulnerable patients. We therefore encouraged exchanges between mental health and harm reduction professionals, organising a number of opportunities for discussion and skills development, as well as raising awareness of the specific problems of gender minorities and sexual issues. In some cases, sites recruited temporary staff (psychotherapists, psychologists, sexologists, sex therapists, psychiatrists, addiction specialists, etc.) when there was a shortage of expertise.

BENEFITS OF MENTAL HEALTH FIRST AID TRAINING AND AWARENESS OF MOTIVATIONAL INTERVIEWING

Following requests from the pilot sites, the Fédération Addiction and AIDES organised two two-day training sessions. These were aimed at the ARPA-Chemsex project pilots and the professionals working in the relevant structures.

The first training session took place in September 2024 and consisted of training in mental health first aid.

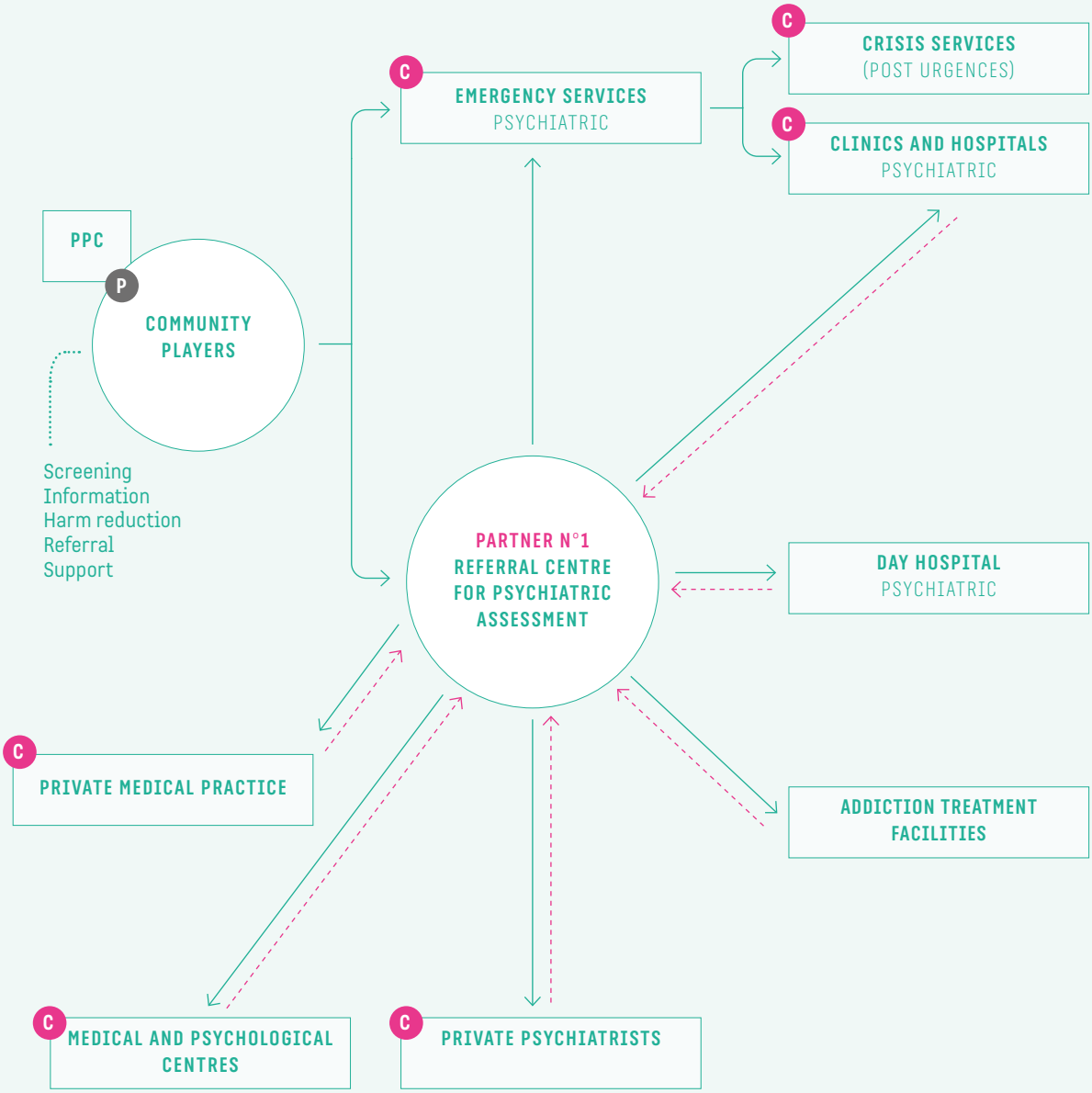
The aim was to improve the ability to recognise mental health problems, to know what to do when chemsexers present and report their disorders, and to be able to refer them to the relevant professionals.

The second session, which took place in November 2024, included an awareness and introduction to motivational interviewing.
The aim was to familiarise participants with the spirit and tools of motivational interviewing.

"I am afraid to admit my addiction, because to acknowledge the problem is to bring it to life"

IDENTIFYING PSYCHIATRIC DISORDERS AND REFERRING TO SPECIALISED PROFESSIONALS

PPC: person practicing chemsex



C Information/training on chemsex P Psychiatric training

CHEMSEX AND PSYCHIATRIC DISORDERS: RECOGNITION AND INTERVENTION

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MAIN PSYCHIATRIC DISORDERS ASSOCIATED WITH CHEMSEX

Some studies have found that moderate to severe levels of depression and/or anxiety are present in between 12% and 29% of people who practise chemsex (PPC), with a prevalence that gradually increases with time spent practising chemsex (Íncera-Fernández et al., 2021; Nöstlinger et al., 2020). It remains unclear to what extent this cumulative vulnerability is due to the prolonged effects of psychostimulants and other substances used in chemsex, to occasional invasive sexual practices, to a combination of both, or to other factors. Slamming is thought to be an additional driver of anxiety and/or nervous breakdown (Rodríguez-Expósito B, et al, 2024). Whether PPC are particularly vulnerable to suicidal ideation and suicide is still under debate (Strasser et al., 2023). It is known that men who have sex with men (MSM) have a higher risk of suicide attempts than the general population, but a further risk due to chemsex remains to be established.

Other psychiatric disorders that may be associated with chemsex include psychotic disorders, borderline personality disorder and attention deficit hyperactivity disorder (ADHD). Psychotic disorders (e.g. delusions, depersonalisation, paranoia) are thought to be particularly common, with some studies suggesting that they account for between 7 and 37% of PPC (Moreno-Gámez L, et al, 2022). As the upper figure appears particularly high, some studies may have included substance-induced psychotic disorders, which are not uncommon with psychostimulants (Fiorentini et al., 2021) but are not classified as chronic psychotic disorders such as schizophrenia.

Borderline personality disorder is a mental disorder often present from adolescence that combines high emotional vulnerability, emotional dependence on others, low self-esteem, self-aggressive (especially sexual) behaviour and frequent impulsivity (Leichsenring et al., 2024). The prevalence of borderline personality disorder has never been accurately assessed in MSM, but it is thought to be about twice as high in MSM as in heterosexuals, although some authors have expressed doubts about possible assessment bias (Rodriguez-Seijas et al., 2021). In addition, borderline personality disorder is reported to be higher in people (including heterosexuals) who suffer from hypersexuality (Sansone & Sansone, 2011). This disorder is therefore likely to be more prevalent in PPC. Psychological trauma is very common in PPC and is sometimes associated with depression, anxiety and borderline personality disorder. In a large German study published in 2020, 76.8% of PPC respondents reported having experienced at least one potentially traumatic event, of which 36.9% involved a violent accident, 36.9% physical or sexual violence by a stranger, and 34.3% physical or sexual violence by a familiar person (Bohn et al., 2020). Psychological trauma can sometimes damage self-esteem and trigger recourse to uncontrolled chemsex practices, creating a highly destructive vicious cycle (Grégoire, 2016).

ADHD is one of the other major psychiatric disorders most commonly seen in PPC. ADHD is a disorder that usually appears in childhood and is characterised by severe difficulty in concentrating, absent-mindedness and motor hyperactivity (some of which may disappear in adulthood). The prevalence of ADHD in PPC is not known from any international database, although clinical reports from people working with PPC suggest that ADHD is common. As with borderline personality disorder, the scientific evidence is circumstantial. It is recognised that the prevalence of ADHD in people with hypersexuality is very high, probably around 20% or more (Korchia et al, 2022). In addition, preliminary data suggest that MSM are at greater risk of developing ADHD than heterosexual men (Hertz et al., 2022). Finally, ADHD is much more common in people who use psychostimulants, with some studies finding prevalence rates of 50% (e.g. Kaye et al., 2013). Taken together, these factors suggest that ADHD is highly prevalent among PPC, although this has yet to be definitively confirmed.

STRUCTURING SCREENING, INFORMATION, RISK REDUCTION AND REFERRAL TO APPROPRIATE MENTAL HEALTH CARE

Despite the specific vulnerability of PPC to different types of psychiatric disorders, and the complex interaction between these disorders and the effects of hypersexuality and psychoactive substances, identifying and referring PPC to appropriate mental health care is difficult for several

reasons. As with other medical conditions, access to mental health care can be complicated by the phenomenon of double stigma experienced by the PPC population, related to their MSM identity and their substance use (Tubiana-Rey, 2023). In addition, they may internalise this stigma, making it more difficult for them to access appropriate mental health care.

In this complex situation, as with other medical problems, the bridging role of community workers remains crucial. Peers trained in psychiatric screening can identify disorders 'on the spot' and work with the PPC concerned to help them gradually recognise the need to seek help and signpost them to appropriate care. These community workers can also help to inform PPC and reduce risk by explaining the potential links between certain substance use and certain psychiatric symptoms or their exacerbation, such as the increased risk of psychotic symptoms (delirium, paranoia) with the use of psychostimulants such as cathinones, cocaine or amphetamines. These community workers must therefore be trained by psychiatric and/or addiction teams who know and understand the different issues involved in chemsex.

In this context, another key aspect of promoting care is the networking of a chain of downstream actors who are familiar with the population and the problem, in particular to limit disengagement from structures and avoidance of care by PPC. This network must be established between community actors and health professionals (see figure below). Mental health services must be diversified to meet different needs, from referrals to psychiatric emergency and crisis services to longer-term care in public (medical-psychological centres - MPCs), private or independent facilities. They should be structured around a main partner (private practice, MPC, etc.) practising in the field of psychiatry, who will be the main contact for community actors and other services that may be involved. Addiction services must also be integrated into this network, as the problems are often dual (combining addiction and psychiatric disorders). Of course, this network must also take into account the specific characteristics (strengths and weaknesses) of each region. The actors involved in each part of the system must know each other and meet regularly, for example under the supervision of community actors and possibly also on the initiative of local authorities such as the Agence Régionale de Santé (Regional Health Agency).

DEALING WITH SEXUAL ADDICTION AND HYPERSEXUALITY

"Rail by rail, slam by slam, group sex by group sex, I have painstakingly built my prison"

Chemsex, and more broadly sexuality in the gay community, is characterised by performance and intensity. The increased consumption of pornographic content, the multiplication of sexual experiences, the use of virtual tools and the ease of sexual encounters are key markers that are both beneficial and destructive for individuals.

COMPULSIVE SEXUAL BEHAVIOUR OR SEXUAL ADDICTION

PR LAURENT KARILA
Centre d'Enseignement, de Recherche et de Traitement des Addictions, Paul Brousse University Hospital

DIAGNOSTIC SKILLS

Before diagnosing a sexual compulsive disorder or addiction, it is important to rule out **the use of stimulant psychoactive substances** (cocaine, MDMA, methamphetamine, synthetic cathinones) or **antiparkinsonian drugs, acute manic or hypomanic episodes** as part of bipolar disorder, or paraphilia (voyeurism, exhibitionism, paedophilia, etc.).

The following clinical criteria should be observed **for at least six months:**

- → significant **loss of time** due to sexual behaviour that interferes with non-sexual goals (activities, marital relationship, work, family, etc.); for example, watching pornographic films becomes a major activity;
- → **repeated sexual activity** because of a dysphoric emotional state. For example, sexual activity becomes a rigid mood stabilisation strategy;
- → **repeated sexual activity** because of stressful events;
- → unsuccessful attempts to reduce or **stop sexual behaviour**;
- → **loss of control** after several days of abstinence;
- → **continuing sexual behaviour** despite physical and/or emotional and/or social risks;
- → **frequent and intense** sexual behaviour;
- → significant **personal dysfunction** in various aspects of the person's life.

Compulsive behaviours can take different clinical forms, such as masturbation, real or virtual sexual relationships with consenting adults, online sexual activities, inappropriate use of smartphones for sexual purposes, visits to massage parlours, sex clubs, saunas, back rooms and compulsive flirting.

To carry out an assessment, use the PEACCE questionnaire (French adaptation of the Carnes PATHOS questionnaire).

1. Do you often find yourself obsessed with sexual thoughts? **(Thoughts)**
2. Do you hide some of your sexual behaviour from those around you (intimate partner, family, close friends, etc.)? **(Entourage)**
3. Have you ever sought help for a sexual behaviour that you don't like? **(Help)**
4. Has anyone ever been emotionally upset/hurt because of your sexual behaviour? **(Consequences)**
5. Do you feel controlled by your sexual desires? **(Control)**
6. Do you feel sad after sex (intercourse, internet, other)? **(Emotions)**

A score of 3 or more is consistent with sexual addiction.

IDENTIFYING AND TREATING PSYCHIATRIC AND ADDICTIVE CO-MORBIDITIES

This involves a wide range of people. Some key points are:

- → abstinence is not the goal;
- → risk and harm reduction;
- → acquisition of a new social repertoire;
- → psychological treatments: motivational interviewing, cognitive and behavioural therapy, marital therapy, before moving on to an analytical approach once the disorder has stabilised;
- → second line pharmacological approach (without MA) if psychotherapy is insufficient: selective serotonin reuptake inhibitor antidepressants (paroxetine, citalopram), opioid antagonists (e.g. naltrexone), N-acetyl cysteine;
- → self-help groups such as DASA (Dépendants affectifs sexuels anonymes – Anonymous Sexual Emotional Dependents);
- → treatment of psychiatric, somatic and social comorbidities.

SOBER SEX – SUPPORTING PEOPLE TOWARDS PRODUCT-FREE SEXUALITY

"The hardest part is regaining your libido afterwards"

Rather than imposing one model over another, chemsexers who are experiencing problems with their practices can also return to product-free sexuality (sober sex) as part of their coaching. In fact, the decision to stop using drugs allows some of them to find more time for other activities, to enjoy (or rediscover) sexual pleasures, to form (again) emotional and social bonds with gay people, and to (re)connect with their everyday environment.

In this context, the road to a product-free sexuality can be long and complex. It is therefore important to support people who practice chemsex (PPC):

→ stopping drug use is not the only solution, but is part of a range of possibilities, depending on the chemsexer's desire and motivation;
→ the process of returning to product-free sexuality is a long one, so it is important to focus on the timeframe involved;
→ people may relapse: this is part of the support process and does not mean that it has failed. It is important to be able to discuss this freely with the patient in a friendly environment and to see what they would like to do after a relapse.

CHEMSEX: A THREE-PRONGED THERAPEUTIC APPROACH

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Chemsex is unique in that it examines both the use of psychoactive substances and the scripts of sexuality. This dual approach confronts health professionals with holistic, transdisciplinary issues of prevention, management and risk reduction. At a time when the demand for pleasure and performance has been the basis of our representative and ritualised society for the last forty years, taking 'chemical' substances to have 'sex' has become a way of expressing pleasure pushed to the limit, to the point of suffocation. But apart from the idea of pleasure, isn't chemsex more of a 'sexual disorder' in our society? A means of coping with heteronormative pressures, doubts and performance anxieties through ritualised, penetro-centric, climactic practices? Through chemsex, the focus is on 'relationships' and representations of stereotyped sexuality. Insofar as chemsex is part of complementary but distinct ('addictive' and 'sexological') problems, support and care require long-term follow-up. From a psychotherapeutic perspective, a three-pronged psycho-addict-sexological approach is particularly recommended. Sexoanalysis, a mind-body approach and all cognitive-behavioural therapies have their place (motivational interviewing, decisional balance, change and maintenance techniques, acceptance and commitment therapy (ACT), mindfulness, EMDR, etc.).

Dismantling chemsex also requires a sex-analytical approach. It involves deconstructing the patterns of chemsex in order to build on the patient's personal appetites and scripts in reorganising their own sexuality. Therapeutic support must also enable chemsexers to explore and discover the secondary sexual characteristics of their bodies (remember that the whole body retains erogenous properties) as well as the primary sexual characteristics (genital area, penis, testicles). Learning about degenitalisation, putting pleasures back into context - especially by practising slow sex - or analysing fantasies and their practices/representations are good sexological tools for preventing harm and rethinking the self. They help to rebuild trust in the body and in relationships (after inhibition, illness, surgery, exposure to sexual assault, etc.). Finally, the issue of consent remains one of the most important current areas of prevention in our society. When drug use and sexuality go hand in hand, the concept of consent is not easy to understand or respect. In the field of harm reduction, information and awareness-raising about consent in the context of chemsex are still a priority.

PROPOSALS FOR PROFESSIONAL ACTIVITIES

INITIATIVES IN THE AIX-MARSEILLE AND LYON PILOT SITES

THE AIX-MARSEILLE PILOT SITE HAS DEVELOPED A SERIES OF PROFESSIONAL ACTIVITIES FOR CHEMSEXERS:

→ individual and group yoga classes were offered on the first and third Tuesdays of each month;
→ group writing workshops were also organised for two hours every fortnight by an external facilitator;
→ sailing workshops were offered, consisting of four outings on a sailboat, each lasting three hours, in the presence of two chaperones (including a CSAPA nurse), giving the chemsexers the opportunity to help set up the sailboat. This activity was organised in partnership with an association. It allowed chemsexers to escape from everyday life, to develop new emotions, to create links with others and to have a collective activity other than consumption;
→ meditation groups led by a former user and choreographer. The activity enabled people to work on the sensation of breathing and the altered state of consciousness, and gave them tools to improve their mental relaxation. Other activities were also developed, including art (six workshops) and dance.

THE LYON PILOT SITE ORGANISED TWO HEALTHY CHEMSEX WEEKENDS:

These weekends included various workshops ('harm reduction', meditation, self-care and personal mental health, auriculotherapy and the NADA [National Acupuncture Detoxification Association] protocol), opportunities to discuss with professionals and to get together (meals, games, walks, etc.). The aim of the weekend was to have some time for oneself in a community setting and to make connections between people.

Occupational activities can therefore take many different forms and have a variety of positive benefits. Non-medical social and community activities are organised and programmed with a therapeutic and occupational aim to offer new life horizons to chemsexers who are interested.

Chemsexers often express feelings of loneliness and isolation. These factors can lead to excessive drug use and addictive behaviour. Lack of social skills is also one of the most common concerns: many of them describe having relationships only with other chemsexers, in a sexual context and under psychoactive substances.

Occupational activities are essential to encourage interaction and socialising outside of chemsex, and to help people manage their drug use more effectively. Boredom and occupational or social inactivity are key determinants. Occupational activities need to be co-constructed with people and be seen as a source of enjoyment. Occupational activities are not aimed at drug withdrawal, but are an integral part of the range of techniques designed to improve people's quality of life.

**"I didn't think I would do it again after the first time.
In fact, I thought it was pretty rubbish.
Everyone was on their phones and nobody was actually screwing"**

PUTTING GRINDR AND CO. IN THEIR PLACE

FLORIAN BARDOU,
journalist

"I first installed the Grindr app in August 2012. I was 21, as single as you can be at that age, and my mum had just given me her old iPhone 3. I was already a fan of dating sites, particularly the late Za-Gay, an LGBT platform for under-25s, and was keen to see what this new dating tool - launched in the US in 2009 - had to offer. Twelve years later, I can't say I've been disappointed (laughs). Between two romances (and sometimes during one), I've certainly met some important people (who are now friends), but above all I've seen gratuitous and widespread violence (racism, validism, serophobia, internalised homophobia, transphobia). My feelings of loneliness have increased, I've lost self-confidence and self-esteem because I thought I didn't conform to certain standards of beauty, I've had lots of offers to get high on a Monday at 8am, and I've had some disappointing, if not pointless or shitty, booty calls. I've also wasted a lot of time that could have been spent doing something else. But I just couldn't let it go. Whether alone or in a relationship, I always had the reflex to log on, scroll endlessly through profiles and wait for the potential little game of virtual seduction to surprise me. I'm not talking about an addiction, but over the last few months, after careful consideration, I decided to uninstall Grindr and co (Tinder, Hinge, etc.) for as long as possible in order to return to a little more authenticity in my encounters, whether sexual or romantic. This led to a series of articles in Libération at the end of March about the growing weariness of many users, both heterosexual and gay, with online dating. This disenchantment has as much to do with the way these tools are designed to keep their customers as with our confusion about the existential questions of love, relationships and singlehood. We gay and bisexual men - or men who have sex with men - also share the fear of growing old and growing old alone in a society where LGBTphobia (ambushes, violence of all kinds, discrimination) is rampant. Maybe that's why some people get lost in it, thinking they might find some connection and comfort. But since Grindr is not entirely blameless - the American company is being sued again in the UK after being fined a record amount in Norway for selling its users' sensitive personal data to advertisers without their consent – it may be time to put it in its rightful place, either muting it for as long as possible or, for the brave, uninstalling it from your smartphone. Sexuality outside of Grindr, Scruff and the like is possible. There are still open bars, clubs, saunas, back rooms and open air, pick-up spots where you can meet people and have casual sex, depending on whether you're looking for anonymity or not. There are also parties, friendly or militant associations, etc. where you can meet people. Let's exercise our right to disconnect so that we can get back together and rediscover happier pleasures!"

**"I can propose a date in a month.
A month? ONE MONTH?
Do you know how many times I can die in a month?"**

MENTAL HEALTH MANAGEMENT RECOMMENDATIONS

Listen to people's specific requests, without prejudice and with kindness.
Consider all contextual factors. The patient must be willing and able to consent to treatment.
Although many signs (severe addictive behaviour, psychopathological disorders, psychosocial disorders) suggest the need for specific care by a health professional, this must be proposed and argued for as respectfully as possible.

A psychiatrist or an addiction specialist are not the only possible contacts. Referrals can be made to a community self-help group, to other organisations such as Narcotiques Anonymes, or to a therapist (psychologist, addictologist, sexologist).
Many chemsex addicts are isolated – from care and from social life – and struggle to find someone who will listen to them.

Treatment does not always involve hospitalisation (as services are often overcrowded). Depending on the person's income, treatment in the city or at a community sexual health centre is also a good option.

Associations and training institutes offer a wide range of training and awareness-raising courses. Primary care workers should be trained in the specifics of chemsex, as well as early recognition of mental health problems and interview techniques such as motivational interviewing.

Few facilities are equipped to provide all the services involved in this multidisciplinary approach. Priority should be given to networking and partnerships with complementary services, urban doctors or psychotherapists, hospital services, etc.

The main objective is to address mental health issues in order to improve the overall health and quality of life of chemsex addicts, but also to provide early intervention. Today, many chemsexers seek care too late, when they are trapped in a harmful pattern of addiction or experiencing severe psycho-pathological or somatic problems.

Networking, working in a complementary and partnership way: doctors, health professionals, frontline risk reduction workers in the community.

The community or peer approach often has the advantage of encouraging people to speak out, lightening their mood and bringing them back into care without making them feel sick or pathologised.

The following questions should be included in interviews to get a broad, global view of the situation: does drug use have a negative impact on social life, work, emotional life, health, finances or housing? Special attention should be paid to the most vulnerable groups (young users, people unable to express their sexual orientation to family and friends, first-time users, first-time injectors, etc.).

We, homosexuals, gays, queers.
We the queers, we the freaks,
we the monsters of normal life,
we the outcasts.
We exist!
I do exist too!
I exist! ”

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ANNEXES

GUIDELINES

OBJECTIVES

- To identify the needs, expectations and difficulties of chemsexers
- To identify barriers to the development of sexual prevention and drug rehabilitation strategies and tools (practitioners)
- To identify ways of improving the range of services available (sexual prevention, drug rehabilitation and psycho-sexual addiction services)
- To assess the feasibility and implementation of transdisciplinary care

I. PART 1 : SEXUALITY THROUGH THE PRISM OF PSYCHOACTIVE SUBSTANCES

- Sexuality: definition, aspects, paradigms, representations
- Understanding sexuality: sex, gender, sexual orientation, sexual identity
- Knowledge of different sexual practices and their risks
- Quality of emotional and sexual life
- Issues of informed consent under the influence of psychoactive substances
- Erectile problems, erectile stimulants, polyconsumption and other physiological problems

II. PART 2 : SEXUAL PREVENTION

- Knowledge of STIs, hepatitis and HIV (definitions, symptoms, modes of transmission, treatments)
- Prevention messages, awareness campaigns (characteristics, examples of the best known and proven)
- Screening (interests, 'Test and Treat')
- Behavioural prevention (reducing sexual risks, condoms, gel, other contraceptives)
- Biomedical prevention (PrEP, Tasp, TPE)
- Access to and ownership of prevention strategies

III. PART 3 : HARM REDUCTION - DRUGS AND SEXUALITY

- Knowledge of the main psychoactive substances used (definitions, methods of use, desired effects, undesired effects and interactions between different substances)
- Addictive behaviour: management and control of use
- Addiction and sexual overuse
- Adoption of consumption tools and methods

IV. PART 4 : SELF-IMAGE

- Representations (received ideas, stigmas, prejudices and discrimination) associated with product use and chemsex
- Representations (received ideas, stigmas, prejudices and discrimination) of people related to their serological status (HIV and Hepatitis C, Prep)
- Living with one's HIV status (HIV + hepatitis): taboos and discussions on the subject, emotional and sexual life, prevention, everyday pathology and other issues (impact on work, studies, family/ friends, etc.)
- Life without products: comprehensive support for people who are abstinent and in their emotional and sexual life
- Coping (with) an STI

V. PARTIE 5 : **REFERRAL TO CARE AND MEDICAL TREATMENT (EXCLUDING PSYCHOLOGY AND ADDICTION)**

- Early Identification and Brief Intervention (EIBI*) with possible referral depending on problems
- Carers identified for their good practice and LGBTQIA+ friendly
- Carers identified for their good practice in dealing with users of psychoactive substances
- Partnerships with medical analysis laboratories, hospitals and community centres offering screening services

VI. PARTIE 6 : **REFERRAL TO PSYCHO-SEXO-ADDICTION SERVICES**

- Early Identification and Brief Intervention (EIBI*) with possible referral depending on issues
- Carers identified for their good practice and LGBTQIA+ friendly
- Carers identified for their good practice in dealing with users of psychoactive substances
- Partnerships with mental health and addiction services
- Partnerships with CSAPA and other treatment services

VII. PARTIE 7 : **COMMUNITY CARE, SELF-HELP**

- The community approach, peer helpers, support groups: definition, interests
- The self-help group for active chemsexers
- The self-help group for chemsexers at risk of breakdown
- Other thematic group events (prevention, harm reduction, product analysis, etc.)
- One-to-one interviews by peers or community health workers
- Exchange of experiences by peers or community health workers
- Partnerships with community addiction structures (Narcotics Anonymous, harm reduction associations, other groups, etc.)
- Partnerships with LGBTQIA+ community structures

*Early Identification and Brief Intervention (EIBI). Sources: Respadd

EIBI is an intervention method aimed at changing behaviour. It can end with a referral to a specialist service for appropriate treatment if necessary. It is based on kindness, empathy, listening and understanding. It is non-judgmental, altruistic and encourages people to be independent. Identification means trying to influence a person's path based on a perception of risk or harm, and trying to prevent it by proposing an intervention that we know will be effective. Identification can be based on clinical, biological or questionnaire data, as well as on the identification of risk situations. Screening can be systematic, where the general population is screened, or opportunistic, where patients are screened based on specific signals or clues that make it possible to identify a situation that could lead to risk. Offering a brief intervention means intervening for a limited time, often a few minutes, in a unique and personal way, listening to the patient and offering information and advice.

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