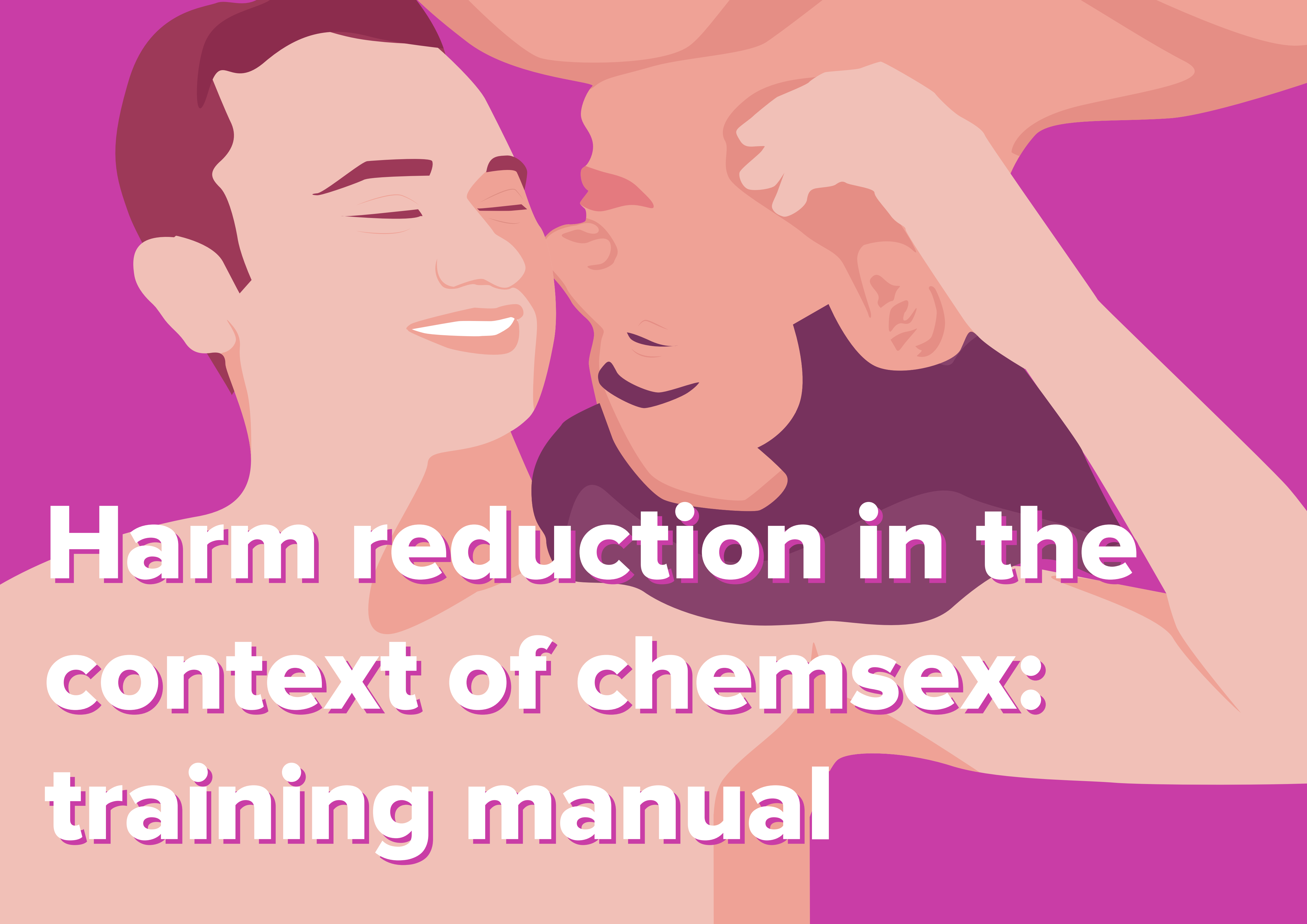
Harm reduction in the context of chemsex: training manual



Co-funded by
the European Union

How to use this manual

This manual is divided in two parts. The first part presents the definition of chemsex, problematic chemsex involvement, harm reduction in the context of chemsex engagement and some core guidelines regarding best practices when delivering services on chemsex. In order to be properly informed, trainers should study this part before they implement training programmes. Of course, the information provided is not meant to make someone expert on chemsex, only to provide a sound basis on this topic. Nevertheless, expertise, if such a thing exists at all, can only be acquired through continued experience, practice and reflection. The first part of the manual could be also a useful resource for anyone interested in chemsex and chemsex harm reduction. The aim of the manual was not to be an exhaustive scientific review. However, it was based on the scientific, clinical or on the ground experience of many resources. These resources are presented at the end of the manual in the references section, sorted by chapter. For trainers who wish to consolidate their understanding of chemsex, that reference section can also be a useful starting point for further reading.

The second part of the manual outlines a training workshop on chemsex and harm reduction. Of course, the proposed workshop will need to be modified to accommodate each specific group of trainees, their needs, the time limits and other resources and limits of each context. All prerequisites, such as necessary materials and detailed guidelines on recommended activities, are given in this part of the manual, so that trainers have the opportunity to be fully prepared to implement the content.

The aim of this manual is to outline a training course that is as interactive as possible, in order to allow trainees to use their analytical, critical and creative skills. We believe that creatively engaging people is essential to giving them the motivation to learn. Trainers are strongly recommended to consider using at least some of the activities and experiential exercises provided in the second part or create some of their own, as they see fit. In order to help trainers present information during the training course, the information provided in the first part of the manual is summarized again in part two, in bullet points. This is, by necessity, a very concise summary, and assumes that the trainer has first familiarized themself thoroughly with part one, in order to be able to answer any questions that may emerge within the group.

AUTHOR'S ACKNOWLEDGEMENTS

The publishing of this manual by AIDS Action Europe is an invaluable initiative. It has been an honour and a great opportunity for me to be a part of this endeavour. I am grateful for the wonderful collaboration with Nina Tumanyan and the insightful exchanges with Ferenc Bagyinszky.

I owe my contribution to this manual first and foremost to my analysands, my students and all the members of the LGBTQI+ community who have trusted me through the years and made it possible for me to keep on learning, reflecting on my work and developing it. I dedicate it to them all.

I would like to express my gratitude to my invaluable companion, Anna Papadaki, for the editing in English, the insightful exchanges and the fun, of course. I am also grateful to my friends and colleagues, Anna Apostolidou, Stavroula Triantafyllidou and Nikos Vegkos for our collaboration, their support and their feedback.

My insights on chemsex would not be possible, had I not had the opportunity to collaborate with and contribute to the Greek Association of People Living with HIV "Positive Voice". I especially thank Giorgos Papadopetrakis, first and foremost for being my friend but also a colleague who has provided so much to the people living with HIV or struggling with problematic chemsex in Greece, with exemplary devotion and kindness. I am also grateful to Marios Atzemis and all we have learnt from him.

Lastly, I would like to express my gratitude to Nancy Papathanasiou and Elena-Olga Christidi, scientific directors of Orlando LGBT+ "Mental health without Stigma", as well as Alexandra Vasileiou and Venetia Bouronikou for our collaboration, which made it possible to keep on developing in providing training but, most importantly, is still offering me the community, if not the family, all we queers strive for.

Author information: Dr. Antonios Poulios is a clinical psychologist, M.Sc., Ph.D. and psychoanalyst. He works in private as a therapist and is also the scientific coordinator of the community projects of the Greek Association of People Living with HIV "Positive Voice". Additionally, he is a member of the scientific and training committees of Orlando LGBT+ "Mental Health without Stigma" and an adjunct professor in the Department of Psychology of the University of Crete, Greece. He was co-winner of the 2022 Symonds Essay Prize, awarded by Studies in Gender and Sexuality journal.

Please cite this manual as:
Poulios, A. (2022). *Harm reduction in the context of chemsex: training manual.* Berlin: AIDS Action Europe

Table of Contents

Table of Contents 7

1. An introduction… 10

2. Chemsex: more than sex and drugs 12

2.1 What is Chemsex? 13

2.2 Where is chemsex? 13

2.3 Why is chemsex? 14

2.4 Chemsex and sexual health 15

2.5 Problematic chemsex 16

3. Substances of sex: chems, effects and harm reduction 18

3.1 Crystal methamphetamine 19

3.1.1 Effects 19

3.1.2 Long term use consequences and medication treatment 20

3.1.3 Mixing with prescribed medication and other substances 20

3.1.4 Harm reduction 21

3.2 GBL (Gamma-butyrolactone) / GHB (Gamma-hydroxybutyrate) 24

3.2.1 Effects 24

3.2.2 Long term use consequences 25

3.2.3 Mixing with prescribed medication and other substances 25

3.2.4 Harm reduction 26

3.3 Mephedrone 28

3.3.1 Effects 28

3.3.2 Long term use consequences 29

3.3.3 Mixing with prescribed medication and other substances 29

3.3.4 Harm reduction 30

3.4 Ketamine 31

3.4.1 Effect 31

3.4.2 Long term use consequences 32

3.4.3 Mixing with prescribed medication and other substances 33

3.4.4 Harm reduction 33

3.5 Cocaine 35
3.5.1 Mixing with prescribed medication and other substances 35
3.5.2 Harm reduction 36
4. Harm reduction in chemsex involvement 38
4.1 Managing risks of chemsex involvement 39
4.1.1 Before 39
4.1.2 During 43
4.1.3 After 48
4.2 Consent 50
4.2.1 What is sexual consent? 50
4.2.2 Consent and chemsex 50
4.2.3 Consent and harm reduction 51
5. Building chems-friendly services 52
5.1 LGBTQI+ affirmative practice 53
5.2 Cultural humility and awareness of power dynamics 54
5.3 Community based practice 55
5.4 Recommendations for effective chemsex harm reduction services 57
6. Skills, practices, and examples of services 58
6.1 Some "clinical" skills 59
6.2 Self / team reflection and supervision 60
6.3 Examples of services 61
6.3.1 Australia 61
6.3.2 Belgium 61
6.3.3 France 62
6.3.4 Germany 62
6.3.5 Georgia 62
6.3.6 Greece 63
6.3.7 Italy 63
6.3.8 Lebanon 63

6.3.9 Netherlands 64
6.3.10 Pakistan 64
6.3.11 Serbia 64
6.3.12 Spain 65
6.3.13 Taiwan 65
6.3.14 Thailand 66
6.3.15 Ukraine 66
6.3.16 United Kingdom 66
6.3.17 United States 67
6.3.18 Vietnam 67

7. Introduction to a chemsex harm reduction course 68

7.1. Before the training 69

7.2. Training sessions 72
7.2.1. Opening up 72
7.2.2. What is chemsex 74
7.2.3. The substances of chemsex 79
7.2.4. Managing risks of chemsex involvement 93
7.2.5. Building chems-friendly services 103
7.2.6. Closure 108

References – Recommendations for further reading 110

Chapter 1 – Introduction to substance use, harm reduction and sexuality 111

Chapter 2 – Chemsex: more than sex and drugs 115

Chapter 3 – Substances of sex; chems, effects and harm reduction 117

Chapter 4 – Harm reduction in chemsex involvement 123

Chapter 5 – Building chems-friendly services 126

01

Introduction

Through the centuries, most societies have made use of some psychoactive substances for different purposes: from social gatherings and feasts, where alcohol consumption is a given, to religious ceremonies and the ritual use of hallucinogens. On those occasions, substance use strengthens social bonds, it reinforces connection and a sense of community. We also use substances as a tool to seek out and enhance pleasure, to transcend our sense of self and the world.

There is no denying that many psychoactive substances can be highly toxic and addictive and their use entails a number of risks that need to be dealt with. Some studies, services or therapy models, go so far as to view substance use as a sign of illness. In most societies substance use, especially when it comes to illegal substances, is conflated with dependence. Both are often is seen as a personal failure or exclusively as the result of personal factors, such as heredity, personality or psychopathology. These views sweep under the rug the many factors that contribute to a person using psychoactive substances. Consequently, they have resulted in our failure to provide people facing substance use issues with the support they want and need, as they are instead blamed, stigmatised and marginalised. Substance use is stigmatised and often criminalised for a variety of political, social and financial reasons. This can further exacerbate the challenges that people who use substances are likely already struggling with, as other parts of their identity, and, in fact, their humanity itself can be ignored and disregarded when their substance use is viewed in this way.

Harm reduction is an alternative approach, a mindset, leading to the implementation of very diverse practices, aiming to minimise the negative impacts of substance use and to promote quality of life and self-determination. Harm reduction is 'working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support' . It usually takes place in a person-oriented, cooperative and community based environment, where people who have lived experiences with substance use take part in planning, facilitating and assessing the harm reduction programmes and services.

It is worth noting that harm reduction can also be a very useful tool for beneficiaries who do aim to cut down on or eliminate substance use. It can allow each person to stay in control of their substance use while giving them the time to reflect and find their own way to reduce their use or abstain, if they desire to do so.

Moreover, harm reduction is particularly important for minorities such as the LGBTQI+ community, sex workers etc., as long as it takes into account the intersectionality of those identities and the obstacles they face due to compounded stigma, discrimination or even criminalisation of those identities and behaviours. Admittedly, not all harm reduction programmes have taken these factors into consideration, nor have all provided affirmative services. Nevertheless, the harm reduction approach has the flexibility required to be adapted to the specific features that chemsex use displays and the particular needs of the people involved.

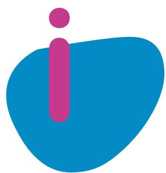
02

Chemsex: more than sex and drugs

2.1 WHAT IS CHEMSEX?

Sexualised drug use, i.e. the use of any legal or illegal psychoactive substance before or during sex, is not new. In fact, substances have been used to enhance pleasure and overcome inhibitions in many cultures through the ages.

Research from the last few decades has shown that sexualised drug use is more frequent among the LGBTQI+ community than other populations. This can partly be traced back to minority stress, which creates a stronger need to connect, to enhance a sense of identity, to deal with painful emotions and to form a sense of community. Meanwhile, for those whose sexuality itself is stigmatised, sexualised drug use can open the door to a pleasure beyond the heteronormative dictates.



The word chemsex was coined by the late David Stuart. Stuart did not just want to name a phenomenon with specific characteristics, but also to provide the people involved in it with a term that could signify their lived experiences and promote culturally competent care for them. So, per Stuart's definition, chemsex is the voluntary use of specific psychoactive substances, often combined, among gay and bisexual men, and other men who have sex with men (GBMSM), trans and non-binary people. Its purpose is to enhance, prolong, disinhibit sexual experience, as well as explore and process queer sexuality. Chemsex commonly involves multiple partners and sexual activities that may last from hours to days. Dating apps play a huge role in its practice.

The substances most used in chemsex, which are often referred to as chems, are crystal methamphetamine, GHB/GBL (gamma-hydroxybutyrate / gamma-butyrolactone), cathinones (mephedrone, 3MMC, 4MMC), usually in combination with ketamine, cocaine, alcohol, erectile dysfunction drugs, MDMA, amyl-nitrates (poppers) and antidepressants. Ketamine and cocaine are sometimes also considered chems. Nevertheless, the preferred substances can vary significantly due to cultural factors, geographical contexts, drug control measures, or supply and demand in each country.

2.2. WHERE IS CHEMSEX?

It is difficult to accurately assess how many people participate in chemsex. Among other reasons, the stigma that chemsex carries means that many research participants will not mention their involvement. There is very little data (if any) on trans or non-binary people.

Having said that, it seems that lifetime rates are particularly high in the USA (reaching 46%) and Western Europe (ranging from 13% to 29%), as well as in some Asian (ranging from 7% to 28%) and South American countries (ranging from 15% to 26%). By contrast, in Eastern Europe, and particularly the Balkans, chemsex involvement seems very low, though in Greece rates are similar to Western Europe. The low frequencies found in some countries, however, may be misleading as behaviours such as chemsex are probably under-reported due to the strong societal stigma, strict punishing laws and less developed support systems there. Nevertheless, these stark differences call for radically different approaches.

2.3 WHY IS CHEMSEX?

Chemsex is more than sex and drugs. According to the position paper of the "2nd European Chemsex Forum" on March 2018 :

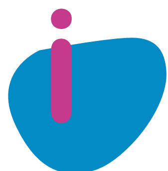
"Chemsex connects uniquely to gay sex, in the context of how the enjoyment of gay sex has been affected by:

- Societal attitudes toward LGBTQ+ people and gay sex.
- The trauma the HIV / AIDS epidemic has had on LGBTQ+ people and on gay sex.
- Chronic bullying of LGBTQ+ people.
- Both explicit and more covert peer pressure amongst gay men.
- The importance of shared ritualised activities in a stigmatised group.
- Community tensions about masc / fem behaviours (or self identities) particularly in regard to the enjoyment of sex and sexual fantasies.
- Gay hook-up technologies and saunas.
- The widespread availability of chems to gay men and trans and non-binary people via gay hook-up apps.
- The reality that MSM, trans and non-binary people engaging in chemsex can also be sex workers, racial and ethnic minorities, migrants and/or prisoners. They may also have mental health diagnoses, other addictive disorders, disabilities, be living with HIV and / or HCV, or be out of the workforce.
- The current trauma of so many lost gay men, trans and non-binary people as a result of chemsex."

Contrary to what some might believe, there is no evidence that chemsex involvement is caused by trauma. Nevertheless, some may process traumatic experiences through chemsex in a pleasurable context where they may feel more accepted. The chemsex experience could actually help in some cases to break free from social conventions and heteronormative or even homonormative dictates that may lead to a suffocating life for many GBMSM, trans and non-binary people. The chemsex experience might even let some people reflect on their identities, choices and experiences. It must be noted, however, that these states are not risk-free, given the fact that chemsex involves potent, highly addictive substances and loss of control, which may sometimes mess things up.

2.4. CHEMSEX AND SEXUAL HEALTH

There is evidence that chemsex involvement makes it more or even highly probable to be infected by sexually transmitted or blood-borne infections, due to the effect of the substances involved on decision making, as well as behaviours like slamming and sharing injecting equipment. However, having such a narrow scope that focuses only on HIV and transmission of other sexually transmitted infections may be contributing to the compound stigma that people involved with chemsex bear, while ignoring other important aspects of the issue.



According to some research findings, chemsex involvement is more frequent among GBMSM who live with HIV than those who are not living with HIV or do not know their status. However, that does not mean that chemsex involvement directly causes HIV transmission. There is also the possibility that living with HIV may increase the likelihood of getting involved with chemsex, in order to cope with the social stigma that living with HIV induces. There might also be other factors related, for example, tendencies to risk-taking, which might raise the probability of being both involved with chemsex and in less safe sexual practices, which, in turn, may raise the probability of HIV infection.

On the other hand, when it comes to sexual health, there is evidence that GBMSM involved in chemsex tend to take some preventative measures to keep themselves and each other safe. For example, they may serosort, i.e. choose to have sex with partners with the same HIV status, as means of prevention, being informed about the dangers that chemsex entails. Additionally, they may get informed about and employ harm reduction, or they may be getting tested more regularly and using Pre-Exposure-Prophylaxis (PrEP) and Post-Exposure-Prophylaxis (PEP) as part of their combination prevention efforts.

When building services addressing harm reduction for chemsex users, we must not disregard that, for many people, consensual bareback sex may be felt as maximising sexual pleasure, liberating, or providing greater connection. After all, we humans tend to prioritise pleasure over physical health. Stigmatising people looking for a more fulfilling access to pleasure, even with means not personally approved by us, may be pushing them into a vicious cycle of shame and self-blame that is very probable to become problematic if self-medicated through substance use.

2.5. PROBLEMATIC CHEMSEX

We must bear in mind that not all chemsex involvement is problematic, at least at any given time. In fact, many people maintain control through various techniques, as well as self-reflection, life planning, social network support etc. On the other hand, there is no clear definition of when chemsex involvement is definitely problematic. What each person considers 'problematic' for themself is highly subjective and affected by many factors. Additionally, not all problems deriving from chemsex involvement are equally severe and the people facing them are not always aware of them, even while the problems are affecting their lives.

Platteau et al. (2019) have provided us with a well-known and important frame regarding the journey to problematic chemsex. According to them, queer people may try to cope with burdened life history or feelings of loneliness, shame and emptiness in various ways, including casual sex encounters, usually with the use of dating apps. One possible way to enhance these encounters, which also happens to be very easy to find on dating apps, is substance use. As Platteau et al. describe, chemsex, being an intense, exciting or even liberating experience at the beginning, but also involving very potent and addictive substances, can lead to a state where substance use may become the major source of pleasure, connection and coping. At this point, tolerance and dependence are very likely, which can be extremely harmful.

It has to be noted that this journey is provisional, as it provides only a rough frame of reference on how chemsex may become problematic. Some key points that should alert us to probable problematic chemsex could be summarised as follows:

- Difficulty in having sober sex, sometimes underpinned by the fact that the last time one has had sober sex was a long time ago.
- Difficulty in enjoying things and activities one was enjoying in their previous life.
- Difficulty in finding something new that looks interesting, or motivation to do things other than chemsex.
- Chemsex involvement systematically lasts longer than planned.
- There are systematically lost hours or even days from work or other activities deemed important by the person involved in chemsex.
- Time with friends, family or other people who are important to our life but not involved in chemsex is diminishing.
- Weekend party and play is the sole motivation throughout the week, it gives meaning to the rest of the days or makes everyday life bearable.
- There are mental health issues emerging (often quite midly at the beginning and gradually becoming more intense and long-lasting, no matter whether one uses substances or not). These issues include sadness, anhedonia, i.e. the inability to experience pleasure, irritability, undue anxiety, intense suspiciousness, emotional outbursts, social anxiety, and, in more severe cases, hallucinations, paranoia and psychosis.

People at different points in their chemsex journey will ask for different types of intervention and have the opportunity for different kinds of self-reflection, self-care and personal growth. For these reasons, it is extremely important to be open to meet each individual where they are and to carefully listen to their input

03

Substances of sex: chems, effects and harm reduction

3.1 CRYSTAL METHAMPHETAMINE

Crystal methamphetamine is a very potent psychostimulant substance that causes overstimulation of the centres of the brain that control emotions, cognitive functions and pleasure. This overstimulation affects the sympathetic division of the central nervous system by releasing dopamine, serotonin and norepinephrine, causing overstimulation of the respective brain receptors, which in turn results in its empathogenic, hallucinogenic and euphoric properties.

It can be smoked, injected (slammed), inserted rectally (booty bump), snorted or ingested orally, in some cases wrapped in a piece of paper to prolong digestion (bombing).

Its street names include meth, speed, ice, Tina, crystal, tweak, crank, and glass.

3.1.1 EFFECTS

- Initially causes higher heart rate, blood pressure and temperature, excessive sweating, rapid shallow breathing, and pupils' dilation.
- Highly increases sexual desire and causes a strong sense of euphoria, especially when the substance is smoked or injected.
- People who use crystal methamphetamine report feeling more confident, losing their appetite and not needing to sleep.
- Increases energy, curiosity, and alertness and decreases anxiety.
- People who consume large amounts may experience hypertension, chest pains, heart failure, arrhythmia, difficulty in breathing, high body temperature, paranoia, severe stomach pain, coma, unresponsiveness, intracranial haemorrhage, seizures and ischemic stroke.
- During the comedown, when the substance effect starts wearing off, people may report experiencing increased anxiety and depression as well as tiredness and headaches.

3.1.2 LONG-TERM USE CONSEQUENCES AND MEDICATION TREATMENT

The prolonged use of crystal methamphetamine leads to tolerance, which, in turn, may lead to higher doses and frequency of use. Furthermore, crystal methamphetamine remains in the brain for a long period of time. Among long-term consequences, we may find:

Dependence on crystal methamphetamine is hard to treat, as there is no medication that can help with abstinence, and no approved relapse treatment medication. Several substances have been proposed in order to help with individual symptoms, including Modafinil, Bupropion, Naltrexone, Mirtazapine and cannabidiol (CBD).

It has to be noted that crystal methamphetamine does not cause serious physical dependence. However, it does cause strong psychological dependence. Its withdrawal symptoms include depression, irritability, anhedonia (being unable to experience pleasure), attention deficit etc. The absence of physical symptoms of withdrawal may not let people using crystal methamphetamine realise they are becoming dependent. Therefore, they might end up consuming more in order to self-medicate the dependence symptoms. This, in turn, can lead to serious problems and even more severe unwanted effects.

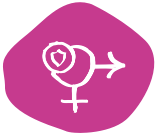
3.1.3 MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

- Certain antidepressants, when combined with crystal methamphetamine use, may cause high blood pressure, increased body temperature, and serotonin toxicity.
- The use of crystal methamphetamine can decrease the effectiveness of medications for psychosis and blood pressure.
- Mixing methamphetamine with other substances, including ecstasy, cocaine, poppers and erectile dysfunction drugs is very dangerous and may cause blood pressure dysregulation, heart attack or stroke.
- Erectile dysfunction drugs are commonly used in combination with methamphetamine in order to bypass the “crystal dick” effect, that is, chronic erectile dysfunction even in the presence of sexual arousal that crystal methamphetamine causes.

3.1.4 HARM REDUCTION

Nutrition

Having a nutritious meal before partying and playing protects from the exhaustion that will follow. Additionally, high fat food protects from the harmful effects of oral uptake of crystal methamphetamine.



Sexual health

If condoms are used, keep in mind that crystal methamphetamine makes its recipient quite tireless and with very intense sexual desire. Thus, condoms are best changed after 30 minutes of sexual intercourse, or they might break. Additionally, water-based lubricants are preferable, as other lubricant constitutions may corrode the latex of the condoms and make them break more easily.

Take a break

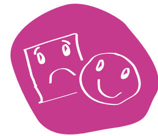
Taking breaks during the chemsex sessions to hydrate by drinking water or juices, having a snack and avoiding to exhaust our body is also recommended. Sugar, caffeine and alcohol should be avoided, while electrolytes seem helpful. Crystal methamphetamine makes people not feel hungry, thirsty or tired, but that does not mean that the bodily needs are not still there. In fact, they may be even greater due to the strain caused by the substances' effects and the sexual activities that take place. For the same reasons, having a shower during a break from partying may be refreshing, while it also helps keep the body clean.

Don't overdo it

Taking smaller doses at longer time intervals may help to keep track of the substance's effects and protect from overdose.

Dental hygiene

In order to avoid dental problems, teeth brushing (in the cases of sessions that last for days), using sugar free chewing gum and hydrating will protect the teeth from the harmful effects of crystal methamphetamine.

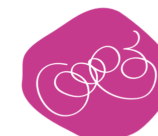


The Comedown

Comedown, that is, the symptoms caused when crystal methamphetamine effect wears off, may be quite overwhelming but they are temporary most of the time.

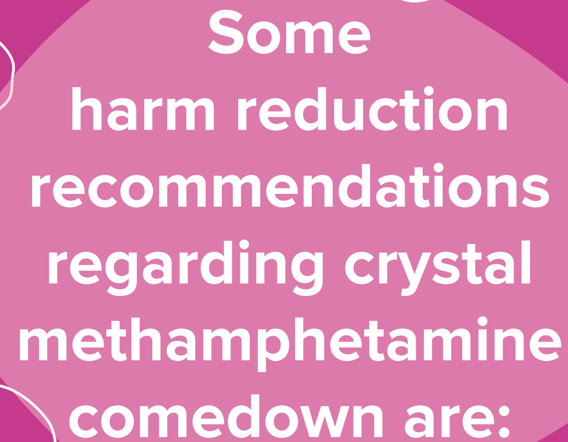
Skin Care

It is also important to take care of skin damage caused by scratching, picking the skin and/or injecting by using proper equipment (e.g. antibiotic ointments) so that the skin can heal properly and infections are avoided.



Concerning psychosis

Crystal methamphetamine induced psychosis is quite common. Its symptoms closely resemble paranoid schizophrenia, including paranoid ideation, ideas of being followed or surveilled, acoustic and tactile hallucinations and confusion.



Consuming nutritious food, including high quality protein, and a lot of liquids (juices, tea, water) is of great importance for the body to recover.

Calcium and magnesium food supplements may also help with anxiety and irritability. Additionally, multivitamin supplements are also important for the body to recover.

If the comedown is particularly overwhelming, reduction of the substance amount used or even taking some distance from chemsex involvement for some time altogether may be a good idea. Overwhelming comedowns are often a sign of dependence. In cases when symptoms are not receding or they are difficult to control, it is important to seek support from a properly trained professional or affirmative community based service.

Having a lot of sleep and being in a quiet and safe environment is also very helpful, especially regarding the recovery from the psychological impact of the come down. Lack of sleep for over 24 hours may cause severe cognitive deficits as well as hallucinations (e.g. insects crawling over the body) and psychosis.

Communication with trusted, non-judgmental friends, family members etc. is important, especially if one has a difficult time recovering and needs to share their feelings with other people – sharing itself may be healing. For the same reason, contact with people and being in environments that are anticipated to cause irritation or anxiety is best avoided. Maintaining a social network not involved in chemsex is useful, in order to be supported and have quality time not connected with substance use, which may help to keep control over it.

Concerning psychosis

According to David Stuart , “common symptoms of crystal methamphetamine include:

- Feeling like people are listening under the door/outside the house.
- Feeling like our phone/PC/electrical items are bugged or hacked.
- Being hyper alert to possible hidden cameras.
- Feeling at the centre of a plot devised by a gang or a cult, or people we recently partied with.
- Feeling like someone has deliberately infected us with HIV/hepatitis C (or something else).
- Feeling convinced that someone has deliberately drugged us without consent.
- Feeling like we are being ‘gaslighted’ (people trying to convince us we are insane, or imagining things).
- Hearing whispers, or cruel persecutory voices.
- Seeing floating presences in the periphery of vision.
- Feeling like insects are under our skin - or a compulsive need to pick at the skin, pick at spots.
- Being hyper-conscious of strange symptoms our body is displaying (joint pain, oddly coloured skin or blemishes, something in our urine or faeces.
- The belief that we can hear the electricity in the walls, or radio signals.
- Being hyper-aware of insects or micro-bacteria in nooks, crannies, fabrics.
- An awareness of incredible coincidences that no one else can see or interpret.
- A feeling of being judged by everyone for being high/having gay sex/wanking/having HIV/being effeminate/being unsexy/not fitting in/for having particular fantasies or fetishes/for watching porn (or particular porn).
- Feeling that something urgent or dangerous is at play, feeling unsafe.
- The feeling of being followed, either electronically or in real life.
- An obsession with solving (or finding evidence for) any of the above.

Crystal methamphetamine psychosis is more probable in cases of dependence, regular use, or overdose, as well as lack of sleep. Although its symptoms may be very frightening, in most cases they will cease if we cease substance use and invest time in proper self-care (e.g. sleep, nutrition, relaxation). There are also cases, however, where the symptoms may remain for several days to weeks or relapse even with very small doses of substance use. In such cases, abstinence could be recommended, as well as seeking support from a properly trained mental health professional and community services. During a chemsex party, if such symptoms manifest, it is a good idea to take a break and seek the company of a trusted partner or partners. Chemsex partners are advised to be kind and calm and help their peers feel safe and relaxed. Trying to persuade them that “everything is in their mind” is a bad idea.

3.2 GBL (GAMMA-BUTYROLACTONE)/GHB (GAMMA-HYDROXYBUTYRATE)

G is a central nervous system depressant, but in small doses it also acts as a stimulant. Its effects are similar to alcohol, or anxiety and sleep medication, causing relaxation and drowsiness.

It comes as a transparent, slightly salty, odourless liquid and more rarely as a white powder sometimes enclosed in capsules. It may be ingested, often mixed with juice, due to its bad taste and the fact that it is caustic when not dissolved, taken rectally or, less often, injected.

Its effects start 10 to 30 minutes after it has been taken and last about 4 hours, depending on the weight of the recipient and the levels of tolerance. G is rather rapidly metabolised, so it can only be detected in the blood for 8 hours after use and for 12 hours in the urine.

GHB and GBL have similar effects, but they are not the same. GHB is the substance that is produced in the body when GBL is taken. GHB is sold in capsules or powder, while GBL is usually liquid, and its potency may vary greatly. GBL has a stronger effect than GHB, but it lasts for a shorter time.

Street names of GBL/GHB include G, Gina, Geebs, Liquid Ecstasy, Liquid X, Liquid G, Goop, Georgia Home Boy, Easy Lay, Soap.

3.2.1 EFFECTS

MODERATE DOSES CONFER:

- euphoria
- sociability
- sexual arousal
- relaxation
- drowsiness
- lack of inhibition

It is also popular with some GBMSM for its relaxation effects that make receptive sex (bottoming) easier and more pleasurable.

OVERDOSE MAY CAUSE:

- dizziness, nausea
- tremors
- confusion, irritation, agitation
- loss of coordination
- hallucinations
- memory lapses
- seizures
- coma
- respiratory arrest and death

Sometimes, overdose may lead to a comatose state named G-hole. Symptoms of confusion, incoherent speech or involuntary muscle contractions are often precursors of the G-hole. A person in the G-hole loses consciousness and falls into a slumber that can last from minutes to hours. It may also lead to respiratory arrest or heart failure, if G has been combined with other substances.

3.2.2 LONG TERM USE CONSEQUENCES

G also causes physical dependence, in addition to the psychological one. That can occur quite quickly, even after three consecutive days of use. Withdrawal symptoms begin 2 to 3 hours after the last dose and can last up to 12 hours and include:

In severe conditions hyperactivity, paranoia, psychosis, seizures or even death have been reported. Signs of addiction include continuing to use the substance even when harmful side effects are evident, tolerance, and withdrawal symptoms if use is stopped. Repeated comas can cause problems in memory function and emotion regulation.

3.2.3 MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

- Mixing G with depressants, such as alcohol, ketamine, opiates, benzodiazepines, is highly dangerous and may result in respiratory arrest, overdose, G-hole and death.
- Mixing G with stimulants is also dangerous for two reasons. Firstly, stimulants will not let the person taking them experience the drowsiness that G normally causes, so they may not realise in time how much G they have taken and suffer an overdose. Additionally, combining G with stimulants makes paranoid, hallucinatory and aggression side effects very likely.
- Combining G with poppers or erectile dysfunction drugs may cause abrupt dysregulation of blood pressure, which can sometimes cause cardiac arrest.

3.2.4 HARM REDUCTION

	Mixing	Combining G with other substances should be avoided, as the results could be very harmful, even fatal.
	Pre-existing conditions	In case of a previous diagnosis of blood pressure problems, seizures, respiratory problems, depression or panic disorder diagnosis, it is advised that G be avoided.
	Knowing who to trust and what to take	The source providing G should be trustworthy, as the composition of the substance is extremely important, especially in the case of GHB. If purchased through the dark web, there are no guarantees of the potency, so it is better to be careful and not guess at the right dose based on previous purchases. Additionally, one has to be completely sure whether they are using GHB or GBL, as GBL is significantly more powerful. An amount of GBL that is equal to a regular dose of liquid GHB may be lethal.
	Duration	Continuous use for over 6 hours should be avoided, as it may lead to overdose or dependence, followed by unpleasant withdrawal symptoms.
	Diluting	G should be diluted in water, juice or other non-alcoholic drinks, as it is caustic and will burn the mouth, pharynx or stomach, if ingested without being dissolved. Additionally, drinking it straight from the bottle increases the risk of overdose.
	Don't rush	G use should start with smaller doses (usually 0.5 to 1.0 ml but depending on the body weight) to prevent overdose - actually, one has to wait in order to check if the dose taken was right for them, as its effects usually take at least 10 minutes to manifest. There have been cases of overdose to people thinking that the dose was too low without having waited enough.
	Checking one's own dose	Doses should be decided on and checked by the person taking them. Due to the fact that the proper dose for the desired effects varies among people based on their tolerance levels and body weight, a regular dose for one person could be too high for somebody else. It is useful to have a way to tell cups apart during a chemsex party, to make sure that each participant uses their own G. Different cup colours or name tags are useful for this purpose.
	Measuring	Syringes (or other lab tools that can accurately measure ml) are the best way to measure the quantity to be taken. For G, dose accuracy is very important. Even a small departure could result in severe overdose, so spoons or bottle lids are not safe measures. Slamming and booty bumping is better to be avoided due to the high possibility of bladder or vein damage and overdose.

Storing

G is safely stored in bottles not used for other liquids. Because it is transparent, it may easily be mistaken for water or other colourless beverages and a person could take too much thinking they are drinking something else before realising it has been G.

Taking enough time and keeping a record

Because G requires some time to take effect, while its effect is compounded by multiple doses, one should wait at least two hours before taking more, in order to avoid overdose. It is recommended that each G dose is smaller than the one before. Moreover, G influences memory, so one should keep track of when each dose was taken. Using a mobile phone for this record can be very useful.

Cutting down

Stopping G use abruptly in cases of dependence should be avoided as it may cause very dangerous health problems. In such cases, it is better to gradually reduce the dose one takes or seek medical help, in order to be supported with proper medication.

Withdrawal

If someone has severe withdrawal symptoms, they should refer to a hospital emergency department.

Spiking

Spiking is the phenomenon of mixing G with alcohol without the consent of the person who is going to drink it. Obviously, spiking aims at sexual assault. This may also happen by secretly mixing G with lubricant as a means to sexually assault the person with the receptive (bottom) role in sex. In order to avoid this, it is advised to have your own lubricant or use small closed packages of lubricants, especially if you are participating in a chemsex party or are about to hook up with strangers.

Regarding assault

Many cases of sexual assault on people being under the effect of G have been documented. G is safer to use in safe environments with at least one or a couple of trusted people. People having sex with partners on G are advised to get a clear consent before proceeding.

Overdose

Signs of G overdose include incoherent sweating, vomiting, irregular or shallow breathing, being unable to stand, involuntary muscle contractions and G-hole. Overdose is more probable in cases where tolerance is high.

- *In cases of G-hole it must be made sure that the person in a coma is in recovery position in order to avoid respiratory blockage that can lead to respiratory arrest.*
- *A person in G-hole is vulnerable to sexual assault, so it is important to keep an eye on them.*
- *It is important to ask for medical help by calling an ambulance, if one is not sure about a partner that has fallen into a coma. Sometimes, other substances (e.g. stimulants) are used to wake up a person in G-hole, but this can be quite dangerous. It is preferable to place the unconscious person in recovery position, not leave them alone and to be honest to the medical staff regarding the substance that caused the coma. In most countries medical staff only has to call the police in cases of violence or death, so it is not likely for somebody to face persecution if they have called the ambulance in a G emergency.*

3.3 MEPHEDRONE

Mephedrone is a synthetic cathinone derivative and a substance with psychostimulant effects, similar to amphetamines, cocaine and MDMA. It affects cardiovascular function, perception and emotions and also has a hallucinatory effect.

It can come as a fine white powder, in an off-white or yellow crystal-like form that can be broken down into powder, or as a mustard- or custard-coloured cream. The ranges in colour are mainly subject to its constitution. Its smell is described as bad and its taste as metallic.

It is used by snorting, swallowing (bombing) or slammed, as well as in pills or capsules, smoked or rectally (booty bump). A moderate dose, orally taken, takes approximately half an hour to come to effect, and the effect lasts for about 3 to 4 hours. Snorting and slamming work a lot faster. When slamming, it is described that there is a sudden strong rush after the injection before the high.

Street names include Meph, 4MMC, Kitty Cat, M-Cat, Food Plant, Bubbles, Crubs, Meow-Meow and Drone.

3.3.1 EFFECTS

- sense of euphoria
- alertness
- confidence
- sexual arousal and focus
- affectionate emotions
- a sense of connection to others
- high attention, sometimes becoming obsessive

POTENTIAL PHYSICALLY HARMFUL EFFECTS INCLUDE:

- dehydration
- sweating
- teeth grinding and jaw clenching
- changes in body temperature
- muscle twitching
- vertigo
- headaches
- changes in blood pressure
- pain and injuries in throat and nose

HARMFUL PSYCHOLOGICAL EFFECTS INCLUDE:

- anxiety
- hypervigilance
- dizziness
- paranoia
- craving to redose (especially in slamming)
- loss of short term memory
- insomnia

OVERDOSE, WHICH IS MORE PROBABLE IF SLAMMING IS USED, INCLUDES:

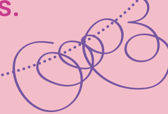
- convulsions
- tachycardia
- fever
- may be lethal, mainly by causing a heart attack

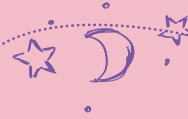
3.3.2 LONG TERM USE CONSEQUENCES

Mainly psychological dependence.

Tolerance develops rather quickly and causes craving for larger doses and abuse, which, in turn, leads to a number of other harmful effects.

For people with dependence, the positive effects of mephedrone turn into mood swings, aggressive behaviour and psychotic symptoms. These can be similar to crystal methamphetamine induced psychosis, which includes auditory, olfactory and tactile hallucinations.





Long-term use of mephedrone causes exhaustion due to insomnia, lack of food and dehydration, especially over long periods of use.

Calcium disturbances in the body and teeth grinding due to mephedrone can bring about dental problems, while chronic blood pressure dysregulation can cause heart damage, stroke and visual issues.

3.3.3 MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

Mephedrone has a number of potentially dangerous effects if mixed or used in combination with a number of other recreational or medical substances.

- Mixing mephedrone with other medication, especially psychiatric and in particular some anti-depressants, may be very dangerous.
- Furthermore, mixing mephedrone with other psychoactive substances, especially other psychostimulants such as cocaine or crystal meth, may cause dangerous blood pressure and body temperature increases, as well as raising the probability of harmful side effects.
- Mephedrone is often used in combination with G or other depressants. As noted earlier, this combination may lead to overdose from either substance.
- Alcohol in particular should be avoided in combination with mephedrone, since this may cause an increase of the heart function, as well as a come down that is particularly difficult to deal with.

3.3.4. HARM REDUCTION

Taking it slow

By starting mephedrone use with a smaller dose and repeating use at long enough intervals, craving for redosing is less likely as a side effect. Bigger doses do not increase the effect, they just make mephedrone last longer. Snorting is best limited to once every 20 minutes and swallowing to once every more than 40 minutes at least.

Weighing doses

Weighing doses is useful to avoid overdose. Doses over 80mg are very dangerous.

Ways to use mephedrone

It seems that the least harmful way to use mephedrone is orally, in which the high is achieved in about half an hour and lasts 2 to 3 hours. By snorting one may cause nasal damage, inflammation and bleeding which may be quite severe in some cases and increase the possibility of a blood borne infection being transmitted, if the equipment for use is shared. Slamming, besides other harmful effects related to intravenous use, is also more risky in regards to overdose. It may even be fatal.

Smoking

In case of using through smoking, the high is achieved rather quickly, but so is the come down. As a result, craving for a redose is very likely. It is advised not to smoke more frequently than every half hour.

Rinsing

It is advised to rinse the nose and the mouth after each use. This will protect the nose, the teeth and the inside of the mouth from corrosion caused by mephedrone and will protect the stomach from the toxicity that the substance will induce by helping the substance dissolve.

Nutrition

Eating nutritious food and drinking water is very important to protect the stomach in cases of oral use. Furthermore, it provides energy and helps avoid dehydration. Mephedrone makes you feel like you have a lot of energy, but actually it consumes the energy deposits of the body. Additionally, through the strong sweating side effect, one is very likely to be dehydrated and suffer problems. Rehydration is advised to be achieved by non-alcoholic beverages.

Cooling down

In case of overheating, it is useful to find a quiet and safe place to have a break. It could also be useful to remove some clothes or lower the body temperature by drinking cold water.

Protecting the eyes

If on mephedrone, it is also advised to wear sunglasses in order to protect the eyes from the pupil dilation that mephedrone causes, making them vulnerable to sunlight.

Keeping it short and sweet

Partying for over one to two consecutive days is quite dangerous. Insomnia can be very dangerous and likely to cause psychosis.

3.4. KETAMINE

Ketamine is known for its anaesthetic, analgetic, antidepressant and anti-inflammatory effects with reported side effects including increased salivation, increased heart rate, systemic arterial pressure and intracranial pressure. It also has psychoactive effects, including sedation, vivid dreams, dissociation (disorientation over space and time), psychomotor disturbances, memory and cognitive impairment and hallucinations, which seem more probable or intense if a person is suffering from any psychiatric issues.

As a psychoactive substance, it comes as a colourless, odourless and tasteless liquid and, more frequently, as a white powder or tablets.

It can be mixed with non-alcoholic drinks, snorted (sometimes with the use of bullets to measure the doses in order to avoid overdose), swallowed (bombing), mixed with water and injected into the muscles, or delivered rectally through booty bumps. Its effects last 45 to 90 minutes, if snorted, and up to 3 hours, if swallowed or injected. There is no known antidote for ketamine.

Its street names include K, Special K, Vitamin K, Ket, bump of K, Kiddy/Techno smack.

3.4.1 EFFECT

In chemsex, ketamine is often used to complement the effects of other substances. Its effects vary depending on the body weight, tolerance, its combination with other substances, the dose quantity and the potency of each individual batch. It confers:

- a feeling of floating, detachment and relaxation, making it easier to have hard sex and practices such as fisting
- a sense of euphoria, happiness and peacefulness
- sexual arousal and disinhibition

ITS HARMFUL EFFECTS INCLUDE:

- dysfunction of the urinary tract
- difficulties in erection and ejaculation
- dizziness, nausea and vomiting
- ataxia (loss of motor control)
- nasal irritation
- extreme dissociation
- panic attacks
- bad trips with frightening hallucinatory experiences

3.4.2 LONG TERM USE CONSEQUENCES

Ketamine does not seem to cause physical dependence. However, it has been reported by some to cause psychological dependence and craving which, in some cases, can be dealt with by gradually reducing the amount of substance taken. Long term consequences of use or frequent use may cause:

dysuria, painful haematuria and urgency of urination, kidney dysfunction

K-cramps, i.e. intense and otherwise medically unexplainable abdominal pain

psychotic disorders

impairment in cognitive functions, including memory and learning problems

The effects in urination tend to cease when use stops, but there have been cases that surgery was needed.

A well-known side-effect of ketamine is the K-hole. That is a comatose condition, which is characterised by its dissociative and sedative effects.

SIGNS OF AN UPCOMING K-HOLE ARE:

- blurred vision
- intense hallucinations
- feeling detached from one's body
- feeling that death is imminent

K-hole often ends without further problems apart from some disorientation, but in a K-hole one is vulnerable to sexual assault and accidents from falling etc.

COMEDOWN SYMPTOMS INCLUDE:

- feeling down and anxious
- memory loss
- flashbacks or visual hallucinations.
- Withdrawal symptoms on the ground of psychological dependence include anxiety, tremors, sweating, loss of appetite, nightmares and depression

3.4.3 MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

- Mixing ketamine with depressants such as alcohol or G is quite dangerous, as well, as the compounded central nervous system, depression may result in severe respiratory and heart dysfunction.
- One should also be careful not to combine ketamine with crystal methamphetamine, cocaine, and ecstasy as these combinations may cause harmful heartbeat increase, confusion and risk of injury.

3.4.4 HARM REDUCTION

Identifying the substance

As ketamine comes in powder, one should be very careful during chemsex parties not to mistake ketamine with any other powdered substance. Its regular dose is much smaller than that of other substances (e.g. cocaine or mephedrone). Similarly, ketamine tablets often have imprinted images on them and thus they may be mistaken for ecstasy.

Taking it slow

It is advised to begin with small doses and to be careful not to use frequently in order to avoid overdose and other health problems, as the ones described above.

Pre-existing conditions and mental health

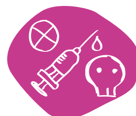
Using ketamine when one is feeling depressed or anxious or dealing with mental health issues is dangerous, as the substance is likely to aggravate those mental states. Furthermore, if heart, liver or high blood pressure have caused issues in the past, ketamine should be avoided.

Mixing with other substances

Ketamine should not be combined with central nervous system depressants. Stimulants may also cause unpleasant interactions, as the stimulants may counter the sedative effects of ketamine and vice versa. Consequently, the substances may reach highly toxic levels in the body.

Smoking

Smoking in combination with ketamine use may be dangerous. In cases of K-hole or motor inhibition generally, there is risk of fire or burns that may not be immediately felt due to the substance's depressant and anaesthetic effects.



Injecting

Injecting ketamine is best avoided due to the fact that it may cause a number of blood, skin and other cardiovascular issues. Injecting in the veins should be avoided as it may be lethal.

Keeping an eye out for injuries

The pain relieving properties of ketamine may make hard sex easier and more pleasurable but they entail the danger of internal injuries that may not be realised on time.

Using with friends

Similarly, it seems that using ketamine on one's own is not a good idea, especially in cases of bad trips or K-holes. Using ketamine with trusted people with whom one feels safe is important in order to get help or be protected from sexual assault in cases of K-hole. Generally, ketamine will lower inhibitions and thus increase the probability of taking risks that would not be taken otherwise, this is an additional reason to use ketamine in the presence of a trusted company.

K-hole

In case of K-hole, it is advised to move the person somewhere quiet with no bright lights and call the ambulance if they do not wake up. While a typical K-hole varies according to the amount of substance used, means of use etc., if its duration is more than 90 minutes, the people present should be vigilant, especially if respiratory difficulties are presented.

Seeking out a K-hole

In cases where ketamine is used in order to experience a K-hole, one is good to be sure of the safety of the environment and should be seated or lying in a place where it won't be possible to suffer injuries from falling.

Being honest with medical staff

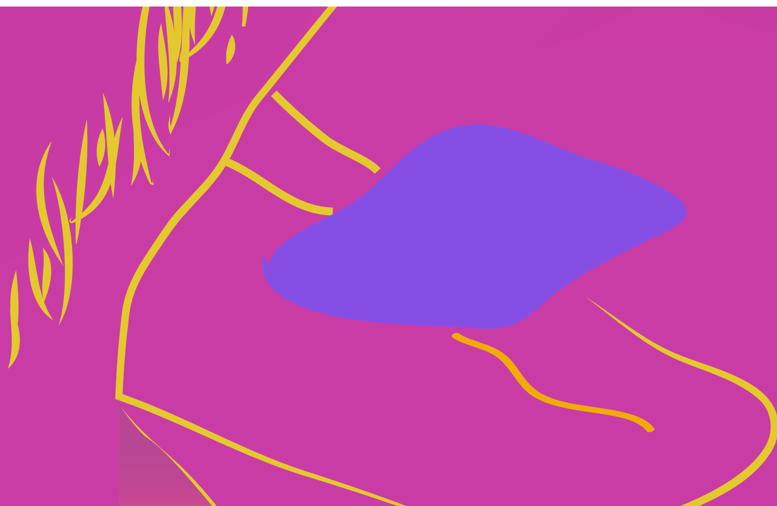
When dealing with medical staff in cases of ketamine overdose, one should be honest in order to receive the proper treatment. Likewise, a ketamine user is also advised to inform their physician if they are to have a surgery in order to receive the proper anaesthetic dose.

3.5. COCAINE

Cocaine and crack, both popular in recreational psychostimulant substance use, are rather well known. While not typically included among chems, cocaine is often used in a sexual context and in combination with chemsex substances.

3.5.1 MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

- Using cocaine with antidepressants affecting serotonin brain function may be dangerous. It can lead to a syndrome which causes palpitation, sweating, convulsions and insomnia.
- Benzodiazepines may counter the psychoactive effects of cocaine and lead to an overdose.
- Paracetamol may increase the adverse effects of cocaine on the liver.
- There is also some evidence that systematic cocaine use may decrease some antiretroviral medications' effectiveness.
- Cocaine seems to mildly block the effect of amphetamines and other psychostimulants. At the same time, it puts strains on heart functions, increasing the risk of stroke or heart failure.
- Using cocaine in combination with G also requires caution, as it may cause respiratory problems, even respiratory failure. Additionally, as in all combinations of psychostimulants and depressants, this combination may lead to a cocaine overdose.
- Mixing ketamine with cocaine, a combination also known as "Calvin Klein" may dangerously increase ketamine's toxicity in the body.
- Mixing cocaine with alcohol is quite risky as well, because the two substances are compounded in the body producing cocaethylene, a substance harmful for the heart and liver, which may even cause death.



3.5.2 HARM REDUCTION

Testing before use

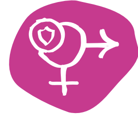
Cocaine is often adulterated in a way that can be very harmful. One should be careful and test it before use. This can be done with proper chemical equipment and reagents. If there is no access to such equipment or services, one could taste a very small dose. Cocaine numbs the tongue quickly. Additionally, if melted, adulterated cocaine does not melt evenly and the procedure takes time.

Taking it slow

It is advised to start low and slow the use and try not to take too much (over 60 mgs) in a too small period of time. The effect duration of a moderate dose usually lasts for up to 20 minutes, depending on the tolerance one has developed. Chronic cocaine use may lead to renal, gastrointestinal, cardiovascular, neural and mental health problems.

Grinding down

Cocaine is best grinded to very thin powder in order to be used more safely and avoid overdose.



Sexual health

Regarding sex, cocaine gives energy, sexual arousal, confidence, endurance, heightened senses as well as stronger and longer orgasms. However, it makes one more compulsive, increasing the probability of not employing safer sex practices. Moreover, the intensity of sexual intercourse on cocaine and its anaesthetic effects (sometimes it is rubbed on the anus in order to have harder sex) may lead to broken condoms and injuries that may increase the possibility of blood borne infections. Therefore, it is a good idea to take small breaks during sex in order to check out that everything is OK.

Regarding overdose

There is no consensus of how much cocaine can cause overdose. However, overdose may be very harmful, even fatal. Signs of overdose include seizures, confusion, tremors, respiratory problems, nausea and vomiting, tachycardia, high body temperature, paranoia and hallucinations, as well as panic attacks. In the face of such signs, it is important to cease use and call an ambulance.

Pre-existing conditions

A person facing heart, respiratory, liver, kidney, seizure or psychiatric issues, should avoid cocaine use.

04

Harm reduction in chemsex involvement / use

Harm reduction practices can be applied before, during or after chemsex. Following a recent review , we sort the guidelines here into those three categories. It is important to note that harm reduction should not only tackle issues that directly have to do with substance use itself. The overall quality of life that the person(s) involved in chemsex enjoy(s) also needs to be considered here. Lastly, we address consent in the context of chemsex, an area exceptionally important but not always openly discussed.

4.1. MANAGING RISKS OF CHEMSEX INVOLVEMENT

4.1.1 BEFORE

SELF-CARE

IT IS IMPORTANT TO REFLECT ON OUR LIFE AS LGBTQI+ INDIVIDUALS

Having a fulfilling life where pleasure and gratification do not exclusively come from substance use and casual sex can help protect us from some potential harm. Investing more time on being creative in our own unique ways, having a fulfilling network of people with mutual care and affection are some good ways to achieve this. Having a fulfilling life is definitely not in our hands only, especially when we belong to discriminated groups of people having faced adverse events in our lives, dealing with homonormativity, or during times of societal crisis. Even in such occasions, connection is a remedy; connection with other people, communities, social actions and our own selves, our needs and desires. As Fawcett[21] describes, the journey to self-healing may be burdensome sometimes, but it leads to personal growth and a life worth living.

A HEALTHY LIFESTYLE IS PROTECTIVE

Nutritious nourishment and exercise strengthen our body and organism and thus reduce some harms that come from chemsex (e.g. exhaustion, lack of food and/or drink etc.).

USING DATING APPS

Dating apps may provide easy and sometimes immediate access to pleasure, but they can also be quite addictive. They sometimes function as slot machines. They make us believe that, if only we spend some more time on them or view some new profiles, it will provide us with the 'jackpot" partner. This rarely happens. More often, we end up spending too much time scrolling, far more than we intended to, without any gratification. This leaves us frustrated and we miss out on potentially more fulfilling opportunities. Combining substances with app use may intensify this course or even make us take too much substance while we are looking for sexual partners. Additionally, it is important to be respectful and kind with each other in these contexts; discrimination and stigma are important factors of problematic chemsex involvement. Purchasing substances through dating apps can be risky. It is a good idea to find ways to have the substance(s) tested.

[21] *Fawcett, D. (2015). Lust, Men, and Meth: A Gay Man's Guide to Sex and Recovery. Wilton Manors, FL: Healing Path Press.*

TAKING OUR TIME AND CHECKING THINGS OUT

It is important to consider the safety of chemsex involvement before engaging in it and while still being sober. The venue (private house, sauna, cruising place) must be trusted and feel safe. Peers, internet forums etc. can offer information. If hooking up, it is important to trust the person/people we are meeting or get acquainted with them enough to feel safe (i.e. take some time!). It is important to go to chemsex parties with friends or trusted partners so that each will take care of the others. If we are going alone to any unknown venue and are unsure about its safety, we can inform a couple of trusted people of this (even give addresses or use location sharing) and maybe inform them when we get there (or leave).

PLANNING AHEAD

In order to keep control, it is useful to plan when sober what we want to use and for how long, what kind of sex we want to have, what boundaries we want to set regarding sex and substance use.

USING IN ORDER TO FEEL BETTER, NOT LESS BAD

In order to protect ourselves, it is a good idea to use substances when we are well to be even better. Using substances to overcome difficulties makes it more possible to become dependent on them or face their harmful side effects, given that their effects depend a lot on our mood when we use them. In the same manner, if we are dealing with mental health issues, we should be very careful in substance use, as that may exacerbate our symptoms. It is important to receive the proper mental health care by well-trained professionals or other means, such as peer-support groups, rather than to self-medicate.

CHECKING ON MEDICATION

If we are taking any kind of medication, we should honestly discuss our intention to use substances or our participation in chemsex with a trusted and non-judgemental healthcare professional, in order to be informed about potential harmful interactions. If we do not feel safe to discuss such issues with the doctor we are being treated by, we should find someone who will give us that safe space. Community services or other peers from our community may propose such referrals. There are also online sources (e.g. the HIV drug interactions website by University of Liverpool: https://www.hiv-druginteractions.org/) where we can check for potential interactions between medications and substances.

CHEMSEX AND SEX WORK

If we do sex work, there are several aspects we need to consider if we are involved in chemsex during our work. It is useful to have clear boundaries that are also clearly communicated to our clients in advance. It is also a good idea to make sure we get paid before chemsex involvement and stick to the predetermined time duration of our services. Community groups and services, as well as the internet, can help us get informed regarding harm reduction specific to sex work. Rekart et al. [22] have also published a useful review on harm reduction when doing sex work.

[22] *Rekart, M. L. (2005). Sex-work harm reduction. The Lancet, 366(9503), 2123-2134.*

SEXUAL HEALTH

HIV MEDICATION

Some antiretrovirals, are found to prohibit the metabolism of the psychoactive substances in the liver and consequently make an overdose more likely. These include cobicistat (Tybost) and ritonavir (Norvir), used in several combination pills, as well as the protease inhibitor atazanavir (Reyataz), the non-nucleotide reverse transcriptase inhibitors nevirapine (Viramune), and efavirenz (Stocrin/ Sustiva), which can also be part of combination pills (e.g. Atripla), We should be particularly careful if we are taking these medications. Consulting with our HIV specialist is important to be sure that we minimise any harmful interaction between antiretroviral medication and chems.

GETTING TESTED

It is important to get tested for sexually transmitted infections regularly in order to be treated, but also not to transmit any of them to our partners by accident. If we regularly engage in chemsex activities, being tested every three months is a good idea. Community testing centres and sexual health clinics are often friendly and safe for LGBTQI+ people.

LUBES AND CONDOMS

It is also useful to purchase or be provided with lubes and condoms before engaging in chemsex, to prevent sexually transmitted infections transmissions.

LEARN ABOUT PREP AND PEP

We can get informed about Pre-Exposure-Prophylaxis (PrEP) and decide whether we would like to use it in order to be protected from HIV transmission in case we do not use a condom (bare backing). If we are using PrEP, it is useful to consult with a sexual health specialist in order to get tested with the proper frequency to check for other STIs as PrEP only protects from HIV, and to check for very rare but possible side effects from PrEP use.

GETTING VACCINATED FOR VIRAL HEPATITIS A AND B (HAV/HBV), AND THE HUMAN PAPILLOMAVIRUS (HPV)

Vaccination for HAV, HBV and HVP, as well as meningitis and MPOX in some countries, is recommended for GBMSM, as they protect our health from infections quite probable in the course of sexual activities. This is even truer in cases where multiple partners are very likely, such as in the context of chemsex. Additionally, they protect our partners.

CONSIDER USING PEP OR PREP FOR STIS

There is some evidence regarding the use of azithromycin and doxycycline antibiotics as PEP or PrEP for bacterial infections (such as syphilis, chlamydia or gonorrhoea). However, they are not yet well documented and there are concerns for the potential development of antimicrobial resistance due to their casual use.

SUBSTANCE USE

LEARNING ABOUT HARM REDUCTION

We can learn about harm reduction regarding the substances we are going to use through various sources (e.g. internet, leaflets, and trusted people) and community services (e.g. sexual health clinics). This way, we will be ready to deal with any problems that might turn up.

TAKING CARE OF OUR EQUIPMENT

As clean equipment is extremely important to prevent infection transmission, we should prepare and check everything we are going to use (straws, pipes, sterile needles etc.). We can either buy that equipment or, in some cases, get it from relevant services. When slamming in particular, it is important to make sure to be equipped with enough sterile needles, syringes and other equipment used for the injection.

CARING FOR EACH OTHER

TALKING TO EACH OTHER

Discussing personal habits, substance use and sexual preferences as well as related boundaries with potential partners before engaging in partying and playing is important to avoid unpleasant or even bad experiences. Sometimes, it feels awkward to discuss such matters, especially in cases of hook-ups, but it helps to take care of each other, overcome inhibitions and may even become part of the foreplay and fun if discussed in a playful, respectful and kind context. As a matter of fact, if the aim of chemsex is for everyone to have pleasure and fun, those discussions are in everyone's best interest.

PERSONAL HYGIENE

It is a good idea to keep our nails short, especially if we are interested in fisting. Similarly, we should remove rings, bracelets and watches in advance.

4.1.2. DURING

SELF CARE

STICKING TO THE PLAN

Using a logbook (e.g. in a mobile phone or in written form) may be useful to keep track of the amount of substance we have used and when we could take more safely. In case any problems occur (such as an overdose), there will be information on the substances taken. Additionally, keeping the time limits set for chemsex involvement will help to avoid being exhausted or missing important activities the following day or days. Missing work due to chemsex may cost us our job. Furthermore, missing other important responsibilities and activities may cause shame and frustration and these emotions may lead to self-medicating through chems. This can create a vicious cycle, ruining the experience and probably leading to problematic use. Of course, in case something unexpected and exciting happens during an encounter, it may be deemed worthwhile to depart from the plans. It is preferable to make a conscious choice of such a departure where logging your activities and plans can be a supportive mechanism.

LOOKING AFTER PERSONAL ITEMS

In case we are visiting an unknown venue, a common place, such as a sauna, or are outdoors or among people we do not know, it is useful to have our personal items somewhere safe. Moreover, it might be a good idea to avoid carrying large amounts of money (this may also protect from buying more drugs when high than what was decided when sober and lose more money than we intended or even suffer an overdose) and other valuable equipment. Small pouches or keeping money and credit cards in socks we are wearing is helpful for this purpose.

TAKE A BREAK

Taking breaks is important, especially when being involved in chemsex over longer periods and sex parties as exhaustion is an important cause of harmful effects, including psychosis. During these breaks, having nutritious snacks will help to protect the stomach and give us energy. Hydrating (but not drinking more than three glasses of water or other liquid per hour) with non-alcoholic and probably caffeine-free beverages and having a shower will also protect and cool the body and keep it clean. Lube or other substance residue on the body may carry tiny amounts of blood. Similarly, washing and disinfecting hands between partners is important for everyone concerned. Cooling down a little may help us re-enter the party refreshed but also gives the opportunity to have a chat, discuss and get connected with interesting people. Chemsex has a lot to do with connection and connection is more than just sex.

SEXUAL HEALTH

CONDOMS AND LUBE

Condoms can protect both us and others from some sexually transmitted infections. Lubricants help to avoid injuries, including open wounds and bleeding, which would make infections more likely. They can also increase sexual pleasure. It is better not to share lubricants and not to rely on saliva as it dries rather quickly and chems actually decrease saliva production.

TAKING CARE OF OUR TOYS

It is generally a good idea to use our own sex toys or disinfect them before use. Toys, dildos and rectal douches that are made of silicone are easily disinfected by immersing them in a mixture of one part bleach and nine parts water for at least 5 minutes and rinse afterwards. Any grease from their surfaces should be removed before disinfection.

SUBSTANCE USE

LOOKING AFTER OUR EQUIPMENT

Clean equipment for drug use is of paramount importance, in order to be protected from injuries and infections.

- **Straws** for snorting should be clean and get changed often
- **Snorting** with banknotes is a bad idea. They are quite dirty and snorting may even cause some small bleeding that is difficult to notice but makes us vulnerable to bacterial infection.
- **Glass pipes** should also be intact and temperature tested. Cracks and pipes that are too hot may injure our lips and make us vulnerable to blood-borne infections. Some people find it useful to use mouthpieces made of heat-proof materials.
- **Injection** entails quite a few risks and possible harms. As such, it is covered in detail in the following section.

SLAMMING / INJECTING CHEMS

Although the very strong and rapid highs it provides can make it tempting / attractive, the dangers it entails (dependence, overdose, skin and blood infections etc.) can be very harmful. However, in case of slamming, one should consider the following:

- In order to avoid infection, injection equipment needs to be sterile and only used once. Additionally, it is important to thoroughly clean hands and to disinfect the area with disinfecting tissues that is about to be pierced, in order to avoid infection.
- Slamming in the veins should be done very carefully in order to minimise injuries. It is very important not to slam in an artery. Arteries are deeper than the veins and, if they are injected into, there will be a lot of blood and pain. In case of an accident, the needle should be removed immediately, put pressure on the wound with sterile equipment and urgently get medical care if the bleeding does not stop within 5 minutes.

- Using the same needle many times may reduce the sharpness of the needle and thus can easily injure the veins and cause a number of problems in blood flow, heart function and skin health.
- If a vein to inject is not immediately found and one wants to try again, they should use new sterile equipment and not inject into the same site.
- Slamming into the hands should be avoided, as those veins are quite fragile.
- Areas under the waistline should also be avoided, as regular slamming into this area may cause severe blood circulation problems.
- Injecting in areas that are swollen, wounded or hurt should be avoided.
- If using water to dilute substances, it should be boiled and let cool down before use.
- Used injection equipment should be kept safely, e.g. using an empty bottle with a cap, before disposing them.
- If an injected area is swollen, hurt, exhibits skin damage or change of colour that does not recede, a physician should be consulted!

NOT SHARING IS CARING

Sharing equipment carries high risk for the transmission of sexual and blood borne infections. It is useful to have different colour bands and nametags in order to tell our own substance use equipment apart.

DON'T MIX SUBSTANCES

Combining substances can be dangerous and may have unpredictable effects, probably even more than could be covered in the previous chapter. It is better to choose which substance we prefer and only use that substance during a single session. Using substances with which we are not familiar also carries risks, especially if we are in a relatively unknown venue with people we do not know. It will cause stress and we are more likely to have unwanted psychoactive effects. So, when we want to try a new substance, it is better to be sure that we have been informed to the point that we feel safe to use it. Additionally, in a chemsex party, in the peak of the high and the excitement, it is possible to confuse substances, e.g. powdered ones. It is important to be able to tell them apart easily and use the one we actually intend to.

ERECTILE DYSFUNCTION MEDICATION

Many people use erectile dysfunction medication during chemsex to feel confident, maintain lasting erections during prolonged sexual intercourse or tackle the erectile dysfunction effects that many chems (especially stimulants) cause. However, frequent use may cause dependence or interact harmfully with other substances. It is better to take smaller doses over longer time intervals, according to the indications on each erectile dysfunction drug. Taking a break from chems and porn may help to ameliorate dependence and its harmful effects. Otherwise, consulting a sex positive health professional could be helpful.

DRIVING

When on chems, as with alcohol, we should avoid driving. Psychostimulants may give the impression that they sharpen our senses and make us more efficient drivers. However, they could also impact our judgement, which is important when driving, which will make driving risky both for us and others.

CARING FOR EACH OTHER

Taking care of each other is of paramount importance and necessary in order for all participants to have fun! Playing with trusted partners is safer but also increases the pleasure and the exploration of sexual practices.

GOING WITH FRIENDS

It is preferable to join chemsex parties with trusted friends. In the course of the activities or during breaks, we may want to check on each other to make sure everyone is well and having fun. In case things get out of hand or unpleasant side effects manifest, we should invest as much time as necessary in taking care of each other. For some people it is useful to decide that one among a company of friends is going to keep tighter control over their use so that they keep an eye on the others, similar to when going out for drinks, the one who is driving doesn't have (too much) alcohol.

SHARING SUBSTANCES

If we are offering a substance to a partner, it is important to inform them on its effects and its probable side effects and not pressure them to use it, if they are not feeling sure.

SAFE WORDS

We may want to consider setting a safe word, as BDSM practice does. The safe word will be agreed upon by everyone in advance. If anyone says it, then whatever is happening must stop and that person must be looked after.

KINDNESS IS SEXY

Good sex, including very hard good sex, in any way each one of us defines it, requires trust. Being caring, kind and respectful, and looking after those who might need help, is sexy.

MAKING THE VENUE SAFE

In chemsex parties or when hosting one:

- It is useful to provide condoms, disposable gloves, clean towels, disinfectant wipes or sprays, plastic sheets, and paper towels.
- A quiet chillout room or corner is useful for us to take breaks.
- We should remove grease and oil from surfaces (sex slings, toys, furniture etc.) and then disinfect them before changing partners or sexual role or position.
- We should keep snacks and water handy and in sight, in order for the participants to be reminded to stay hydrated.
- Also, when hosting a chemsex party, it is useful to make sure that valuables are out of sight and locked. Maybe a room will be off party limits.

IF SOMETHING GOES WRONG

In cases of emergency, for example if somebody passes out, is disoriented or confused or acting weird, in terror or great anxiety, we need to take care of them!

- It is best to move them to a quiet place with no strong stimuli, such as music or lights.
- We should speak to them in a calm and reassuring tone or put them in a recovery position and stay with them (it is very useful for them to see familiar faces when waking up).
- In case of psychosis, we should not try to persuade somebody that they are hallucinating or delusional, especially if they do not ask us to do so. It is better to reassure them that they are safe, reflect their feelings and prioritise how they will feel emotionally better in the here and now.
- It is better not to assume the severity of one's condition, especially when they are unconscious.
- If they are unconscious, we should call the ambulance and be honest about the substances they have used. The medical and para-medical staff in most countries are not obliged to call the police, even if there is clear use of illegal substances. The medical and paramedical staff will only call the police in case they confirm that someone has died. In either case, acting decisively may save someone's life.

4.1.3 AFTER

SELF-CARE

NOURISHMENT

Relaxation, quality food and drinks and proper sleep during the comedown period can help. Amino acids and other nutrition supplements (vitamins and minerals) can also help with the comedown (either through high quality protein or food supplements).

GIVING OURSELF TIME

It is useful to end the session early enough to have enough time to overcome the comedown. Skipping work or other activities will not help recovery and, in fact, may be harmful to us in other ways.

BEING KIND TO OURSELF

If things went wrong during chemsex involvement, we did things that we may regret, lost control, had a bad trip etc., it is very possible to feel shame, self-blame and guilt. These emotions can make the comedown more difficult. We should not react to mistakes in judgement, things going wrong, sexual explorations that went astray with accusations, self-blame and punishment, but rather with kindness and reflection, to ourselves first and foremost. Chemsex involvement may be some means for some of us to overcome or process 'queer trauma'[23], the subjective way an LGBTQI+ person has grown up and dealt with a world inhospitable to our sexuality. An integral part of queer trauma is shame for what each person is. Guilt tripping, though, actually feeds and re-activates this trauma, rather than treating it the way that serves us. An excellent set of essential tools regarding recovery are available[24].

HOW DID THE PLAN GO?

It may be useful to think about the substance use plan that we made before partying and playing. If it did not work well, we may need to reconsider it. If it was not kept, what were the reasons? Was the entire session fun? If not, when did that change? Did something trigger a craving to use, or to use more than we intended to? Those triggers will not necessarily be something very profound, or obvious. They can include a sexually arousing stimulus, for example, or a sudden intense emotion. It is useful to think about these triggers and their role in our departure from the plan or the inability not to use when we desire so.

IS ADDITIONAL HELP NEEDED?

If we realise that duration, amount of substance we took or the practices we were involved in were not the ones planned and we feel remorse about that, especially if this happens frequently, it might indicate a certain level of loss of control. These could be signs that we might be dipping into the problematic chemsex journey, becoming dependent, developing higher tolerance or facing other issues. In such cases, getting help is very important. This help may come from peers, friends, community services or properly trained LGBTQI+ affirmative professionals. It is a good idea to view issues coming up as opportunities for self-care, growth and to connection in a new, more fulfilling way.

[23] *Poulios, A. (2022). Chemsex: Reintroducing Sexuality in the Pleasure and Pain of the Infans. Studies in Gender and Sexuality, 23(3), 171-183.*
[24] *Fawcett, D. (2015). Lust, Men, and Meth: A Gay Man's Guide to Sex and Recovery. Wilton Manors, FL: Healing Path Press.*

SEXUAL HEALTH

PEP

It is important to consider PEP as soon as the session is over, if other protective means were either not used or failed to provide protection. Sometimes, antibiotic PEP is proposed for bacterial infections but there is not yet enough evidence in the area. For these matters, consulting a specialist physician can be helpful.

GETTING TESTED

In any case, it is very important to be informed about the window periods of each sexually transmitted infection test and get tested as soon as the tests will provide valid results.

CARING FOR EACH OTHER

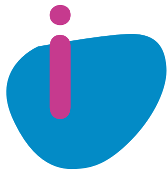
After the session, it may also be a good idea to stay in touch with partners that were not hook-ups only. Discussing what we liked, what can be improved, what may have gone wrong or needs that may arise during difficult comedowns may provide some much-needed care and an opportunity to blow off some steam.

During comedown, while we are reflecting on the last session's events, consent issues may arise. Consent is a very sensitive matter that should be taken seriously. For this reason, we shall discuss it in the next chapter.

4.2 CONSENT

The patriarchy and toxic masculinity in which we have been brought up often makes sexual abuse a taboo topic for people who identify as men and masculinities[25] in general. This makes us even more vulnerable to its effects. These effects are often handled in maladaptive ways.

4.2.1 WHAT IS SEXUAL CONSENT?



Consent is an informed, voluntary and conscious *yes* to the proposal of another person and includes the right to revoke that *yes* at any time. Simple as that might sound, it can get complicated when various factors limit a person's ability to say *no*.

Sexual pleasure is about fun, exploration and, often, a search for transcendence. However, we may not always know in advance what we will find on the way or at the end of this search, or how the experience will affect us. For queer people in particular, sex can be a field where we try to rupture the mould that has been imposed on us or the roles we are performing in our day-to-day lives. In some cases, we may even consent to not consenting, in a way. Such cases include harder sex or BDSM practices, where we can let ourselves surrender to an experience, exactly because we do not know where it will take us. That can be a transcendental experience, but it can also result in unforeseen and undesired events.

4.2.2 CONSENT AND CHEMSEX

As we have discussed above, when people participate in chemsex, a transcendental experience is often the goal. However, the effects of the different substances used, combined with this goal, can blur the lines of consent.

We may consent in advance to taking psychoactive substances for recreational purposes, such as sex, but these substances might later affect our judgement. So, the decisions we make later, under their influence, may not be the same as the ones we would have made sober, which may, in turn, make them less valid. It is not so rare that, in the heat of the moment or a substance high, someone might not understand if they are being given consent to do something. They may even not be able to change their behaviour if they realise that consent is not given, or even not possible. So, they might end up violating someone, which they would never do when sober.

On the other hand, under the influence of chems, a person might not always be able to clearly express a no. If someone has sex with us while we were not fully able to consciously say no that is rape.

It is not rare for someone to only realise later, during the comedown, when the substances' effects have faded, that they consented to things that they would not have agreed to if they had been sober, or that they have acted in ways that they would not have done had they been sober. In fact, this realisation can come several days later, after the comedown is over.

The effects of such instances can be very painful or even traumatic. Not only can they ruin the experience itself, but they might also have other, very serious consequences, which can affect the overall wellbeing of those involved for a long time.

[25]We use here the word 'masculinities' in plural for two reasons. Firstly, it includes people who, while having some traits traditionally associated with men in their gender identity and/or expression, do not neatly fall into the gender binary. Secondly, the word 'masculinities' reaffirms that there are many ways to be a man and/or masculine beyond the confines of hegemonic masculinity that society insists on imposing.

4.2.3 CONSENT AND HARM REDUCTION

Much like with BDSM, our possible involvement in chemsex requires knowing the possible risks it might include and educating ourselves on harm reduction techniques and practices.

BEFORE

As we have also noted in the substance use section, making conscious decisions regarding boundaries and limits before partying and playing is useful. These need to be communicated with partners before any sexual activity takes place.

DURING

LOOKING AFTER EACH OTHER

Checking up on friends and sexual partners during chemsex parties is important in case their high is too intense for them to consciously consent.

MAKING SURE CONSENT CAN BE GIVEN

It is also very important not to proceed with what we want to do if the other person is not able to consent. Someone in a G-hole or a K-hole will not be able to express whether they want to participate in any activity.

AFTER

IF THINGS WENT WRONG

We should take as much time as we need. Having people we trust around us can be helpful. Pressuring ourselves to speak immediately about our experience is not. It is also important to seek out well-trained professional or community help and care. Signs that things took hold over us and maybe we were traumatised include flashbacks (in everyday life, in dreams or during sexual activities), mood swings or persistent negative emotions, avoidance of sexual activities or a craving to use substances that gets out of control.

CHECKING IN WITH PARTNERS

It is also important to be open to talk about the experience afterwards. A good experience can only be enhanced through communication, while a bad one can be addressed and perhaps partly mitigated, if participants look after each other.

In many legal systems around the world, sexual assault is punishable by law. Getting a person who may not be able to consent involved in sexual activities is also a criminal offence. Looking beyond the legal issues of the matter, moreover, consent has to do with the ways in which we come into contact with other people, be that in the context of a relationship, a date or a hook-up. In order for the experience to be fun for everyone, all participants need to respect each other's right to self-determination, and that any person can withdraw consent at any time, even when things have gotten intense.

05

Building chems-friendly services

Apart from certain strategies, techniques and behaviours, chemsex harm reduction requires a context, a frame for the services provided which will ensure its effectiveness and with proper planning and implementation, will be supportive, empowering or even therapeutic by itself.

5.1 LGBTQI+ AFFIRMATIVE PRACTICE

Given the fact that chemsex is deeply connected with the challenges that LGBTQI+ and especially GBMSM who have sex with men, trans and non-binary people are facing, LGBTQI+ affirmative practice is a prerequisite to providing safe and helpful services. Providing services to non-heteronormative beneficiaries is about more than acceptance and non-stigmatising conduct. It also includes affirming their self-determination as well as cultural competence regarding their lived experience and challenges they face. It also requires us, the providers, to self-reflect on our own prejudices and stereotypes that may hinder our practice, whether we belong to the LGBTQI+ community or not. Training is required in order for LGBTQI+ affirmative practice to be fully implemented. Some basic principles of LGBTQI+ affirmative practice include:

- Recognising and accepting the way LGBTQI+ beneficiaries identify, using the proper terminology and pronouns when referring to the beneficiaries and their identities, experiences and practices. Pathologising the way LGBTQI+ beneficiaries identify in any way is harmful.
- Being aware of the complexities and challenges inherent in coming out, not only regarding gender identity and sexual orientation, but also HIV status.
- Acknowledging the intersectionality of the beneficiaries' lived experience, e.g. challenges related to different age, gender identity, sexual orientation, ethnicity and race, living with HIV, socioeconomic class, spirituality, doing sex work etc. Those factors interact with each other in unique ways that affect each person differently.
- Being informed on important figures, symbols, historical dates and community resources, such as groups, organisations etc.
- Being aware of issues regarding oppression caused by families, social networks, homonormativity, police and policing, laws and policies etc. and the adverse effects that minority stress entails.
- Acknowledging the resilience that each LGBTQI+ person and community has developed and being prepared to facilitate their further empowerment.
- Facilitating the exploration of the experience and identities of LGBTQI+ beneficiaries.

It is crucial to note here that the affirmative practice principles above are not only for beneficiaries. They need to be implemented among the staff of harm reduction services. If we fail to provide an affirmative, safe, accepting, inclusive and empowering context and work frame for our colleagues, we will not be able to do so for our beneficiaries, either.

5.2. CULTURAL HUMILITY AND AWARENESS OF POWER DYNAMICS

The imbalance of power between the service providers and their beneficiaries as well as the fact that the cultural background of the service providers will definitely affect the way they work with beneficiaries not sharing this background, limits the understanding of the beneficiaries' experience and therefore the quality of the services. For these reasons, it is useful to be thinking in terms of cultural humility. Avoiding the position of the service provider as an expert, cultural humility focuses on being prepared for the limits of our understanding. In this way, we can be open to learning from our beneficiaries in order to provide collaborative, person-centred services, tailored to their receivers.

Learning from our beneficiaries means being open and at their disposal to try to understand the way they regard the world and their lives and "willing to be disturbed" by those[26]. It is not relying on them to give us the training we should have taken care of ourselves. Nevertheless, self-reflection regarding the effect of our own experience, background, principles, privileges etc. should always be on our mind. One problem with power imbalance that we often fail to see occurs when we feel we lack the knowledge needed to understand the beneficiaries or when we are overwhelmed by the emotions evoked while providing the service. In these cases, it is very likely that we will unconsciously try to reclaim our power by manipulating them, losing connection or generally ceasing to provide affirmative services, or even malpractice. Further training and personal contact with diverse communities, including contact outside the context of the service, personal therapy and supervision are helpful tools to ensure cultural humility practice.

5.3. COMMUNITY-BASED AND – LED PRACTICE

Community-based and -led services have been established as best practice by the World Health Organisation, especially in the health care of minority, oppressed, stigmatised and diverse populations. Regarding chemsex in particular, community-based harm reduction and community-led services are recommended.

Contemporary community-based care strives to bridge the gap between scientists or trained professionals and "experts by experience", i.e. people whose background is within the communities.

Its components include:

(i) focus on ecological, environmental, financial, political and social factors that hinder or facilitate well-being,

(ii) respect for diversity and self-determination,

(iii) investigation and action guided by principles that questions the status quo that perpetuate social injustice and discrimination, and

(iv) interventions focusing on systems that promote the well-being and self-regulation of systems and communities rather than individual factors and problem prevention.

[26]Vasileiou, A. (2020). Οι δυναμικές ισχύος στη σχέση επαγγελματία ψυχικής υγείας – ωφελούμενου ΛΟΑΤΚΙ+ ατόμου [The power dynamics in the relationship between a mental health professional and an LGBTQI+ beneficiary]. In N. Papathanasiou & E. O. Christidi (Eds.), Inclusion and Resilience (pp. 141–152). Gutenberg.

Some guidelines of a community-based and community-led approach include:

PARTICIPATION

People belonging in the community that the service aims at and have lived experience regarding the object of the services provided should be included in all aspects of its implementation: management, training, planning, delivery and assessment. Obviously, participation is the major component for community-led services.

FIGHT FOR CHANGE

Use of any privileges and power in advocacy and changes in policies that will effectively promote well-being and remove barriers in access to care.

FOCUS ON EMPOWERMENT AND SELF-MANAGEMENT

The intervention or service should aim not just at addressing issues but providing resources and building up the resilience of its beneficiaries, so that the communities may have the greatest agency over their lives possible.

NEEDS ASSESSMENT

The service should be designed based on the needs of the particular population in the specific context (cultural, geographical, social etc.) in which it is going to be delivered. Proper investigation and research, preferably conducted by community members, is the best way to achieve this. We need to be flexible and ready to change our services and practices following the changes in the communities we collaborate with.

1 dose
2 dose

2 hours

1 dose
2 dose

5.4. RECOMMENDATIONS FOR EFFECTIVE CHEMSEX HARM REDUCTION SERVICES

Chemsex has to do with the need for belonging, connection, self-agency and care. For these reasons:

- We should focus not only on decreasing problems but also on facilitating well-being. According to the World Health Organisation, health is not the absence of disease or illness but also the presence of biopsychosocial well-being. The same applies to sexual health: it is not only the absence of issues but also the access to a fulfilling sexual life.
- We need to provide an environment that facilitates the beneficiaries to express themselves and provides opportunities for them to connect to their community on their own terms in a non-judgmental context that promotes self-growth. Working with our own and our beneficiaries' internalised homophobia and the impact of homonormativity is actually chemsex harm reduction.
- Beneficiaries may greatly benefit from feeling accepted and not judged to talk about practices and behaviours that some may consider unconventional, such as multiple partners, polyamory, fisting, BDSM etc.
- Some beneficiaries may not consider their use as problematic, even if it is taking a toll on their lives. They may rather describe their chemsex involvement as sometimes getting 'out of control' or 'too hard', 'constantly craving for sex' etc. In such cases it is not always helpful to persuade them otherwise. It can be better to be present and at their disposal, focusing on harm reduction based on their current needs and planned in collaboration with their perspective.
- It is crucial for us to support and empower our beneficiaries to have a fulfilling, meaningful, pleasurable and fun life, according to their needs and principles, outside their chemsex involvement. This may greatly help them to control their use, and also to have more fun during partying and playing.
- Chemsex harm reduction should be embedded in services that address the needs in a global/holistic manner. Similarly to HIV combination prevention, such services should incorporate substance use harm reduction, sexual health, mental health support, community empowerment and peer counselling, as much as possible. If they have to refer to different services in order for their needs to be addressed, people involved in chemsex may get discouraged and overwhelmed. Community-led sexual health clinics seem ideal venues for such services.
- New technologies and applications are very useful in chemsex harm reduction. They are both cost effective and easily accessible in a virtual environment where people engaged in chemsex are most likely to browse. Additionally, they provide confidentiality for beneficiaries not ready yet to come out.
- Keep an up-to-date referral network for services that are outside of the area of harm reduction but very likely to be needed. Such services may include medical units specialising in HIV and other sexually transmitted infections, mental health services, agencies and NGOs providing support for migrants, sex worker networks and LGBTQI+ associations. Unfortunately, many of these services are not affirmative or properly informed about the issues that people involved in chemsex face. Training the staff of those services is a possible intervention that might be very helpful to our beneficiaries.

06

Skills, practices, and examples of services

6.1 SOME “CLINICAL” SKILLS

Despite the fact that harm reduction is not therapy, there are many times where some clinical skills may come in handy for the service providers. These practices and techniques often require us to undergo further training. This training is an excellent opportunity for us to pursue our own empowerment and self-growth, which are as integral in the community-based approach as those of our beneficiaries. We do not have the space here to analyse every one of those skills in depth, but we have decided to present them very briefly, in the hope that this list may prove a useful starting point for their own further development.

- Motivational interview is a beneficiary-centred directive method, which is very useful for facilitating change in a way that resolves the beneficiaries’ ambivalence regarding issues they face by enhancing motivation.
- Psychological First Aid. This technique is specifically designed to be implemented by community workers and non-mental health professionals in general, aiming to empower and support individuals and communities as well as refer beneficiaries in crisis. It has proved more useful than psychotherapy to first responders in cases of emergency.
- Crisis intervention training. When providing harm reduction services, there are many cases where service providers have to deal with crises faced by their beneficiaries, especially as soon as they build trust with their service providers. Such crises may be some psychotic or other emotional breakdown, sexual harassment, emergencies related to health, work, social network or the law and other traumatic situations. In such cases, it is a priority to refer beneficiaries to the proper, specialised services and agencies. However, before they can be able to take the next steps, the beneficiaries’ current emotional state needs to be ameliorated. Psychological First Aid is handy in such occasions, as our first response may be of paramount importance. As Saakvitne puts it:

> “*a relationship can be therapeutic whether it lasts for five minutes or fifteen years, when it offers respect, information, connection and hope*” (p. 446)[27].

Some general guidelines in this approach could be:

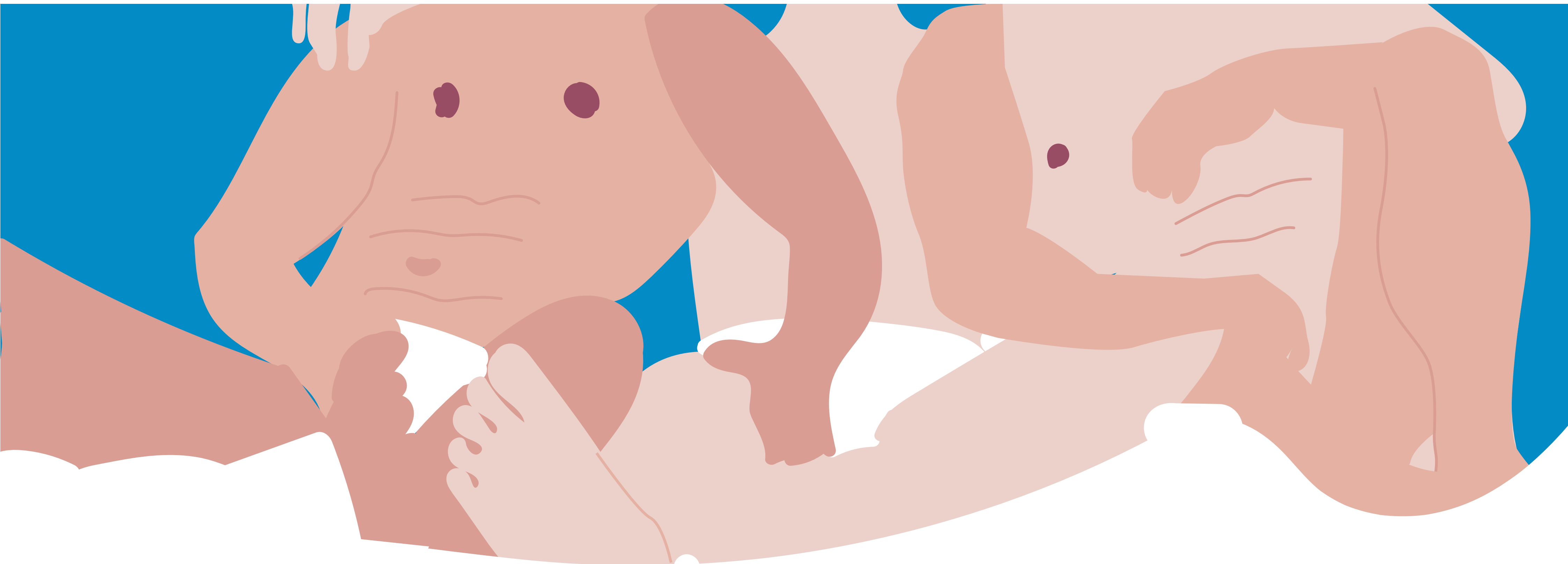
- Respect the way the beneficiary experiences the traumatic event, validate their reaction and the way they have adapted, even if you think that there could be better ways or you do not personally agree with their choices.
- Provide information about what could be expected in such crises and traumatic events as well as resources and services that could be of use.
- Provide genuine connection and presence as well as acceptance of the sometimes devastating emotions that may arise without trying too much to alleviate them or, even without consciously meaning to, give the impression that the beneficiary should not be feeling that way or that they are blowing it out of proportion.
- Provide hope not by promising things that may not be certain, such as full recovery, but by underlining that there are things that may be done or even attempted, that may make a difference in the future, even if their significance is not immediately visible. Keep in mind that hope is giving perspective when there seems to be none, not promising that everything will be fine.

[27] *Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. Psychoanalytic Dialogues, 12(3), 443–449. https://doi.org/10.1080/10481881209348678.*

6.2 SELF / TEAM REFLECTION AND SUPERVISION

Organisations, services, even entire communities, cannot be sustainable unless they have a “willingness to be disturbed”[28] by new ideas or challenges to their structure and assumptions. Dealing with the complex issues that chemsex raises makes this ‘willingness to be disturbed’ even more important than in other fields. Unconscious beliefs and biases, as well as factors such as suppressive policies, financial problems and others, can challenge our thinking and even interfere with the way we operate in our practice, often leading to burnout, resistance to change and not providing services of quality to our beneficiaries. Supervision can be very useful to process these challenges. This is best done by a professional from outside the service, with enough experience and training regarding issues to be processed as well as group dynamics. Community psychoanalysis[29], a contemporary application of psychoanalytic thinking specifically for communities facing stigma and discrimination, may contribute to the well-being of the community of the service and offer insights tailored to its needs. Even if service providers do not wish for supervision, team reflection meetings should be systematically scheduled. These can be used not just to plan the service but also to share emotions, difficulties, reflect on the dynamics of the team and formulate the best possible person-oriented services for each beneficiary. It is important to consider each difficulty in a “binocular” vision, one that perceives it at an individual level but also as a challenge for the service and its members as a whole, a voice as yet unheard.

[28] *Wheatley, M. J., & Kellner-Rogers, M. (1998). Bringing life to organizational change. Journal of Strategic Performance Measurement, 2(2), 5-13.*
[29] *González, F. J., & Peltz, R. (2021). Community psychoanalysis: Collaborative practice as intervention. Psychoanalytic Dialogues, 31(4), 409-427.*



6.3 EXAMPLES OF SERVICES

Building an appropriate service for chemsex harm reduction requires a lot of work and planning in order to provide competent services that take into account the socio-political, cultural and specific community determinants in which the service is going to function. In order to do so, it is of paramount importance to learn from those that have already built such services and, ideally, create a network with them, contributing with your own knowledge and ideas.

6.3.1 AUSTRALIA

THORNE HARBOUR (THERAPEUTIC GROUPS | THORNE HARBOUR HEALTH)

Thorne Harbour is a community-led organisation, with therapeutic groups for people of the LGBTQI+ community. The organisation runs two programs addressing substance use, namely Re-Wired and Defrosted. The Re-Wired program focuses on GBMSM using methamphetamines, and offers group harm reduction, sexual health and mental health management counselling sessions. The service is free for users. One-on-one counselling sessions are also provided, either face-to-face at the organisation's Health Clinic or via telephone. The Defrosted program is a peer-led group for people with previous use of methamphetamines. It comprises an 8-week therapeutic group, addressing topics of relationships, sexual health and well-being.

ACON (www.acon.org.au)

Pivot Point is a project run by Acon focused on alcohol and drug use harm reduction. It provides a website (www.pivotpoint.org.au) that features resources for the LGBTQI+ community on alcohol and substances, party and play, harm reduction, sexual health and safer sex practices. Beneficiaries can find self-assessment tools for substance use and chemsex, as well as helpful resources on reducing or quitting. The project also offers the PNP chat, a free, peer-led, in-person or distanced, harm reduction and sexual health counselling service.

6.3.2 BELGIUM

EX AEQUO, BRUSSELS NETWORK ON CHEMSEX, THE OBSERVATORY OF AIDS AND SEXUALITIES (www.chemsex.be)

This website is addressed to GBMSM that engage in chemsex. It features resources on sexual health and safer sex, substance use and harm reduction, information on party and play venues, app use and chemsex terminology. The site also features a search app on relevant services.

ALIAS (ALIAS ASBL)

Alias focuses on sex workers health and rights. The project is based in Brussels, providing free and anonymous services. The service distributes condoms and lubricants, sexual health and safe sex information, STIs and HIV testing, information on substances and harm reduction, as well as psychosocial support. The organisation also implements a community-based street-work outreach program.

6.3.3 FRANCE

AIDES (www.aides.org)

AIDES offers an emergency helpline, operating 24/7 on WhatsApp and a Facebook group (Info chemsex by AIDES) for people involved with chemsex. On their site, users can find a harm reduction guide. Additionally, AIDES runs a peer self-help group on chemsex harm reduction. Furthermore, AIDES runs two services, Le Spot Baumchair (Paris) and Le Spot Longchamp (Marseille). These are sexual health clinics providing PrEP and PEP, HIV testing, STI vaccination, psychological support and harm reduction counselling, as well as clean substance use equipment. They also have a special coming together and chill together afternoon on Tuesdays, usually the worst comedown day after the weekend party.

6.3.4 GERMANY

DEUTSCHE AIDSHILFE (CHEMSEX: HINTERGRUND UND HILFE | DEUTSCHE AIDSHILFE)

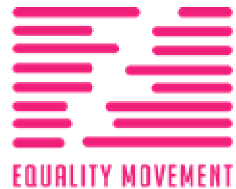
Deutsche Aidshilfe provides a website where people can find information on substances, harm reduction and first aid. The organisation also offers the following services in Berlin, Munich, Frankfurt and Köln:

1) ChemSex Group - Drugs and Sex. Support group for people who engage in chemsex. The group meets on a weekly basis. It provides a safe space for participants to talk about substance effects and consequences, as well as to reflect on use and exchange valuable knowledge and information.

2) quapsss (Quality development in self-help for GBMSM who use psychoactive substances in a sexual setting). A free harm reduction and drug detox and rehab service, addressed to GBMSM engaging in chemsex. The service operates at a group level.

3) Open ChemSex Consultation Hour. The Open Consultation Hour is a free, drop-in service, operating two hours weekly, which offers crisis intervention, a space to reflect on joining the quapsss group, or just discuss chemsex.

6.3.5 GEORGIA



EQUALITY MOVEMENT (https://equality.ge/en/home)

Equality Movement offers an array of services on sexual health and harm reduction in substance use, including a free psychosocial service (social workers, psychologists/ psychiatrist, addictionologist, legal consultation), informational meeting groups and free PrEP & PEP. The service also distributes an HIV Prevention Kit (self-test, condoms etc.) and a Chemsex Harm Reduction kit including materials for injecting and non-injecting use.

6.3.6 GREECE

CHEMSEX SUPPORT

Chemsex Support is a service implemented by the Greek Association of People Living with HIV "Positive Voice". It provides individual peer-counselling on harm reduction, based on motivational interview, psychoeducation and community psychoanalysis perspective. Chemsex support also provides a Facebook webpage (ChemSex Support | Athens | Facebook) featuring harm reduction information and community empowerment posts. In 2023 they are going to hold empowerment open group meetings for GBMSM and are involved in chemsex, facilitated by a member of the community and a psychoanalyst member of the queer community.

6.3.7 ITALY

ASSOCIAZIONE SOLIDARIETÀ AIDS

This association provides a website (www.chemsex.it) where harm reduction regarding substance use, sexual health and safer sex information is featured. Additionally, Associazione Solidarietà AIDS has developed a group psychotherapy service, offered in Milan, focusing on people engaging in chemsex. The group, which meets on a weekly basis, is coordinated by a psychotherapist and an A.S.A. volunteer.

ARCIGAY, LEGA ITALIANA PER LA LOTTA CONTRO L' AIDS

Healthy peers is another website (Healthy Peers) aiming to promote sexual health, reduce substance use harm and address stigma and minority stress. Users can access sexual health resources by navigating through an online "sex park". Regarding chemsex, the site offers information on relevant substances, harm reduction resources and useful links in Italian and English.

6.3.8 LEBANON

NPO SKOUN (https://www.facebook.com/Skoun.org/)

Skoun operates an addiction centre in Beirut, offering HIV, syphilis and viral hepatitis testing, and harm reduction interventions. The centre also offers a psychosocial support and treatment service, consisting of mental health counselling, family consultations, legal advice, and referral service. On their Facebook page, users can find harm reduction guides for substance use and sexual health.

6.3.9 NETHERLANDS

MAINLINE (IT IS MAINLINE'S MISSION TO IMPROVE THE HEALTH AND RIGHTS OF PEOPLE WHO USE DRUGS)

Mainline has developed and implemented a number of counselling and harm reduction services regarding chemsex. Chemsex Support service provides drop-in, in vivo one-on-one and group counselling sessions, focusing on harm reduction and sexual well-being. Chemsex Chat is an anonymous online chat for substance users. Additionally, Mainline offers a needle exchange program and a drug checking service. Mainline has also created the website Sextina (www.sexntina.nl), which focuses on methamphetamine use. The site offers information on the substance, its effects, methods of safer use, on self-control and harm reduction, on sexual health and tips on quitting. The site also features a list of professionals around the country that are familiar with chems and sex.

GDD AMSTERDAM (ENGLISH - GGD AMSTERDAM)

GDD Amsterdam offers a peer-led telephone service for people who engage in chemsex. The service operates two days a week, offering information on substance use and harm reduction.

6.3.10 PAKISTAN

HOPE (https://www.hopecommunity.pk)

HOPE is a community-based organisation in Lahore, Pakistan, aiming to promote the rights and wellbeing of women and people of the LGBTQI+ community. HOPE community-based interventions include a psychosocial support service, substance use/ abuse support groups, legal advice/ advocacy, informational workshops on substance use/ sexual health and legal matters.

6.3.11 SERBIA

NGO RE GENERATION (https://www.regeneracija.org/)

Re Generation offers a peer-led harm reduction service on substance use and sexual health. On their website, users can find information and guides on sexual health and substance use.

6.3.12 SPAIN

STOP. (SIDA) (SEXO Y DROGAS - ONG STOP)

Sida provides a website (chemsex.info) with information on substances and harm reduction, gender and sexuality as well as links to relevant services and a blog. In addition, it implements a number of services. Chemsex Support Service offers inclusive psychological care, psychosocial support and harm reduction counselling, either face-to-face or via telephone. Chemsex Support Commission is a volunteer peer-led team, consisting of present and past Chemsex Support Service users. The group offers emotional support, harm reduction training (face-to-face, via email or apps), peer activities that focus on well-being, advocacy on LGBTQI+ issues, and also runs the "Chemsex Bloggers" website, a space for communication and sharing.

ENERGY CONTROL

Energy Control is a harm reduction programme run by the Bienestar y Desarrollo Association (ABD) NGO. Energy control implements the Specialized Therapeutic Care and Accompaniment (SAE) service, which focuses on substance and internet use harm reduction, offering psychoeducation and counselling as well as psychological support. The service is available in person in Madrid and Barcelona, and remotely for other areas. Additionally, Energy Control provides the Chem-Safe website (Chem-Safe), featuring material on substances and use methods, venues of use as well as sexual practices and safe sex tips. The site also includes links to scientific articles and clinical resources on chemsex. Lastly, Analyze your Chems is a drug checking service, which tests the quality and pureness of methamphetamines, mephedrone and other cathinones.

APOYOPOSITIVO, PROJECT: SEX, DRUGS AND YOU (www.apoyopositivo.org)

The project offers psychological/psychiatric assessment, safer sex and harm reduction counselling, self-help groups for people living with HIV, volunteer activities and community interventions. In addition, the project promotes the Analyze your Chems service in collaboration with Energy Control.

VLC COMITE (www.comiteantisidavalencia.org)

Ciber educator project consists of a telephone or app-based service, offering safer sex, sexual health, drug use and harm reduction information, as well as psychological support. Users can find relevant resources on its website.

6.3.13 TAIWAN

HERO CLINIC (HOME | MYSITE)

HERO clinic is a one-stop service for chemsex users, provided by state-run Min-Sheng Hospital in association with NGO "Love and Hope Association", in Kaohsiung. The service offers LGBTQI+ friendly STI and HIV screening, treatment and prevention education, medical services, PrEP/ PEP counselling, substance use evaluation and counselling, chemsex support and recovery group.

6.3.14 THAILAND

APCOM PROJECT: TESTBKK (TESTBKK)

TestBKK is a community-led initiative, dedicated to disseminating information on sexual health, living with HIV, prevention and treatment services. The website features material on alcohol and substance use, chemsex harm reduction, and also offers prevention packages (condoms, lubricants etc.) including harm reduction material for people engaging in group sessions, which beneficiaries can order from the website.

6.3.15 UKRAINE

ALLIANCE.GLOBAL (http://ga.net.ua/en/)

ALIANCE.GLOBAL runs a project named Partybox (https://www.instagram.com/partybox_ukraine/). Partybox is a chemsex kit distributed to MSM who use non-injecting substances and are engaged in chemsex. The kit includes safer sex and drug use equipment, drug-checking material, HIV self-tests and information on finding PrEP. Furthermore, the organisation offers a peer-led harm reduction counselling service.

6.3.16 UNITED KINGDOM

56 DEAN STREET (56 DEAN STREET)

56 Dean Street offers a chemsex support service, focused on harm reduction, substance use management and relapse prevention. A website is also available, featuring resources on methamphetamine, mephedrone and GHB/ GBL.

TERRENCE HIGGINS TRUST (www.tht.org.uk)

Friday Monday project provides a website (www.fridaymonday.org.uk) dedicated to disseminate information on chemsex and harm reduction. The “Let’s Talk About Chemsex” project consists of an online group, meeting on a weekly basis, addressed to MSM who are involved with chemsex. The group aims at harm reduction and use control.

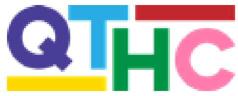
LONDON FRIEND (LONDON FRIEND)

Antidote project is an LGBT-led service dealing with drug and alcohol use. Antidote offers one-on-one immediate substance support, harm reduction counselling, a volunteer based mental health counselling service, and an advice helpline. Antidote also offers the Structured Weekend Antidote Programme (SWAP), an intensive 4 week programme aiming to enhance substance use control. SWAP topics include substance use and harm reduction, sexual health and safer sex and relational issues.

RAINBOW PROJECT (WHAT IS CHEM SEX? - RAINBOW PROJECT)

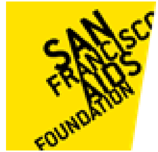
Rainbow Project is an organisation based in Northern Ireland that promotes LGBTQI+ people’s physical, mental and emotional health, as well as their well-being. The organisation offers harm reduction and sexual health counselling online or through telephone calls.

6.3.17 UNITED STATES



QUEER AND TRANS HEALTH COLLECTIVE-QTHC (www.ourhealthyeg.ca)

Peer N Peer is a community and peer-led harm reduction program offering individual counselling and support, an online substance use and sexual health self-screening tool (www.MyBuzz.ca), free clean equipment for substance use and safer use education. The service is free and can be provided either in-person or remotely.



SAN FRANCISCO AIDS FOUNDATION (SUBSTANCE USE TREATMENT - SAN FRANCISCO AIDS FOUNDATION)

The Stonewall Project is a drug and alcohol treatment program for the LGBTQI+ community, based on harm reduction principles, which integrates substance use, mental health, and HIV prevention and education. The service offers drop-in, group and individual counselling sessions, aiming at harm reduction and treatment.

6.3.18 VIETNAM

LIGHTHOUSE (GTOWN)

Lighthouse is a community-led organisation, based in Hanoi Vietnam. The organization focuses on GBMSM, LGBTIQ youth, young sex workers and people who inject drugs. It implements peer-led interventions and runs a drop-in centre called “Lighthouse Clinic” offering information on sexual health and/ or substance use. The project also runs a website, GTown, which offers information and resources on sexual health and substance use, provides links for community pages and forums, and a mobile app, “Hunt”, which links users to local health services.

07

Introduction to a chemsex harm reduction course

This part of the manual provides some guidelines and an outline for training people on chemsex and harm reduction. Such a training could be useful for services dealing with substance use issues, and particularly chemsex, especially if they use harm reduction. It can also be a valuable tool for community centres, sexual health clinics, health professionals working with LGBTQ+ beneficiaries and community workers. In order to benefit the most from this training, it is advised that trainees be already acquainted with the harm reduction approach. Some prior knowledge on the challenges that the LGBTQI+ population faces, HIV and other sexual health issues, as well as the impact of minority stress on biopsychosocial health would also be useful. The training itself addresses these issues, but they are not its main focus.

7.1 BEFORE THE TRAINING

- The trainers should study the first part of the manual and possibly research themselves on relevant topics that are of interest to them. Some bibliography is provided at the end of this manual. The more they have become acquainted with the chemsex phenomenon and harm reduction regarding substance use, sexual health and other related behaviours, the more rich and useful they will be able to render the training to the trainees.
- Some experience with group training would be handy but is not a prerequisite.
- The trainers may decide to put more emphasis on some parts, create their own presentations or shorten the training according to their trainees' needs, the budget, and the time they have to do the training.
- It may also be a good idea to use an online questionnaire before the training, in order to assess the trainees' existing level of knowledge, their expectations and the specific needs of a local service course material. A similar questionnaire may be used at the end of the course to assess its effectiveness.
- The trainers or the training venue should ensure that there will be access to some technical equipment needed for the training; a laptop, a projector, a screen, whiteboard or other surface to project the presentation and other materials, probably a board for the trainer or the group to write on, flipcharts and pens, papers, pens and post-it papers, as well as anything else the trainers may think useful for their course.
- Keep in mind that providing support to people facing problems needs experience, practice and self-reflection. This training provides information and some skills regarding chemsex. Its main aim, however, is to start a conversation among participants and to create a basic framework that they can then use as a jumping off point in order to expand their knowledge and experience even further, developing their services in suitable and unique ways, tailored to the individual beneficiaries and contexts they work in.
- It might be advisable for trainers to also provide trainees with resources and contact details on local service providers dealing with related issues (such as sexual health or sex work) that the trainer considers to be reliable, especially ones that apply harm reduction principles and techniques. Trainees will then be able to continue expanding their understanding and experience, and address any issues that might have been raised during the training but could not be given enough time.

BEFORE PROCEEDING TO THE TRAINING OUTLINE, IT IS USEFUL TO KEEP THE FOLLOWING POINTS IN MIND.

Safe space

Chemsex, dealing with sex, pleasure, excess and identity but also sometimes with dependence, mental health issues, harassment and stigma, is often triggering for trainees, especially in cases they have lived experience in some of its intersectionalities or are dealing with issues related to chemsex. **A priority for the trainer is to provide a safe space for the training to take place and be sure they do so in the whole duration of the training.** They must acknowledge the difficulties that this topic may bring forth consciously or unconsciously, but also avoid opening up discussions to personal issues (see "oversharing" below). Many of the recommendations that follow help to ensure this protection for the trainees.

Training colleagues

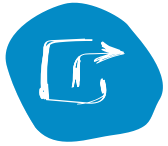
When **training people already working in a service, that is, a group of colleagues that we ourselves may also be a part of**, it is very probable that, during the training, issues may emerge that are related, not to chemsex, but to other dynamics within the group and/or service. In such cases, we should redirect the focus on the object of the training, acknowledging the tension of the group, the challenges of working with delicate matters, such as those that are associated with chemsex, and how they can trigger areas where we also might be sensitive. It is crucial for the service itself to constitute a resilient and strong community in order to provide the best services possible.

Oversharing

It is to be expected that during the training, some participants may share experiences, ideas, emotions etc. In fact, some experiential learning activities that are proposed here include an emotional sharing component. However, this sharing aims at team building and self-reflection, not opening up to personal issues that need to be addressed outside of the training. It is recommended to deal with such instances by politely stopping any discussions on personal issues of any participant in the group and redirect the focus on the training objective even using this sharing. For example, if a trainee shares the anger they are feeling regarding how they have been stigmatised in the past for using substances, it is more useful to thank the trainee for sharing and point out the their experience brings to the table the anger that our beneficiaries may also be dealing with. , Then call on the group to reflect and come up with how we as service providers could address this anger.

Emotions… again

In a similar way, there is a probability that strong emotions will emerge in the training group, including hopelessness (*nothing can be done*), over-enthusiasm (*let's change the world right now*), even boredom (*I don't even know what we are doing here*). These emotions are not to be challenged or addressed but to be welcomed as different experiential facets of the phenomena discussed. This can only be fruitful if they are reframed as being comparable to the experience of our beneficiaries. For example, over-enthusiasm may be something felt by someone just beginning their involvement with chemsex while hopelessness may be the feeling of somebody having stepped too deep in the problematic chemsex journey. The group can then proceed on how to achieve the best possible harm reduction for people feeling such emotions.



Departure from the objective of the training

It is not unusual, especially in complex issues, such as chemsex, for the training participants to focus on interesting or important topics which are not directly related to the course itself. Redirect the attention to the training's goals. Keep in mind that sometimes a successful training ends up with the desire or need by its participants to be further trained on issues that emerged during its implementation!

Team work

Try to make the training as interactive as possible. Information can be sought and acquired by the participants themselves through numerous means. This is a more effective training method than providing information via lecturing. In order to make the course interactive, prefer a seating arrangement that has participants in a circle. The aim is to help the trainees understand what is at stake when delivering harm reduction for chemsex users and reflect on themselves, as well as the service they work in, regarding how to address the issues brought forth by chemsex involvement in an affirmative way for their beneficiaries. For this reason, participants' own views and lived experiences in related areas can be invaluable. Even if the trainer feels that participants' contributions might be unrelated to the topic at hand or too personal (see 'oversharing' and 'departure from the object' above) they should by no means reject those contributions in their haste to return to their syllabus. Remember that chemsex has to do with creating inclusive communities - being able to create a productive and inclusive training "community" is the first step.

Self-care

As in chemsex harm reduction, make sure to have enough breaks during the training for the participants to relax, socialise, or have a snack. You may find it useful to provide small breaks, even unscheduled ones, in cases where you think that the group needs it. Energiser group exercises are also useful as breaks, especially after a difficult or challenging part of the training.

Perfection is a fantasy

There are going to be mistakes, things that in retrospect you would do in a different way or wish you had addressed more productively. No matter how much experience we have, working with different people or on different topics may entail unpredictable pitfalls. In many ways, the best material for self-reflection and learning for everyone is made possible when things do not go the best way imaginable. As Freud said, "From error to error one discovers the entire truth"!

7.2. TRAINING SESSIONS[30]

7.2.1. OPENING UP

SESSION'S GOALS

- To get to know each other and build rapport.
- To set the ground rules of the training and particularly for achieving a safe training space.
- To set the goals of the overall training.

KEY POINTS FOR SESSION I

- Make sure the atmosphere is as warm and safe as possible.
- Make sure that technicalities are addressed so that you may proceed with the training without any stress regarding issues not related to it.
- Have the whole group know what to anticipate from the whole training.

SESSION IMPLEMENTATION

1 Introduce yourself and ask the participants to do the same. Do not forget preferred pronouns!

This may be done casually or through an energiser that would stimulate interest in the course and contribute to team building. Two examples of energisers are provided below.

Catch the ball

Begin by introducing yourself while holding a small ball or something similar. After finishing, throw the ball to another participant and ask them to introduce themselves. At their turn, they will throw the ball to another participant who has not introduced themselves yet and so on until the entire group has had a turn.

A thing you don't know about me

Each participant, in random order, will introduce themselves and share a piece of information that is not known about them. Make clear that the information shared is by no means meant to embarrass or expose the participant! One should share something that feels safe for them. The point is to relax the tension of the beginning and make it fun. Give an example by introducing yourself, e.g. "I am Johan, community worker in harm reduction in X organisation and a thing you don't know about me is that I play dungeons and dragons board games" or "I love mountain trekking" etc. [Optional addition: The activity can also be done with the ball (see above). As an extra step, participants can then pass the ball to each other, saying again the other person's name and the fact that the other person said about themselves, e.g. 'Johan, dungeons and dragons player'.]

[30] Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

2 Set ground rules for the training at the beginning by providing information about its duration, its outline, when the scheduled breaks are, what will be provided at the end (e.g. handouts) and other technical matters. It is a good point to answer any questions from the trainees on technical issues at this point.

Setting the ground rules regarding safety is even more important. This is best done through an interactive exercise like the one suggested below, by letting every participant express themself regarding what they need to feel safe. The climate becomes more welcoming and the group will respect each other's requests more if their requests have been already expressed.

The tapestry of rules

Have a large piece of paper on a board or on the ground and ask the participants to write a thing that is important for them in order to feel safe during the course. Prefer colourful pens. Then put the paper on a wall or somewhere that is clearly visible to everybody and leave it there during the whole course. Add things you deem important at the end, in case they haven't been mentioned. In case you think that it will be difficult for the trainees to express themselves openly at this point, ask them to write their rule on a small piece of paper (e.g. a post-it paper), gather them and then transcribe them yourself on the large piece of paper by adding anything you deem important and has not been mentioned. For this purpose, it might be a good idea to have prepared in advance a provisional list of rules that are not to be left out under any circumstances, though, of course, ideally the trainees will mention all those 'unmissable' rules.

3 Proceed with presenting and setting the goals of the training. You may present them yourself.

For example, a good set of goals could be:

- Understand what chemsex is and what distinguishes it from other types of sexualised drug use.
- Be alert for signs of problematic chemsex.
- Get acquainted with the substances used in chemsex and harm reduction regarding specifically their use.
- Be informed about other harm reduction related to chemsex involvement, apart from the substances themselves (e.g. sexual health, consent).
- Be able to practise harm reduction in a person-oriented approach on an individual level.
- Be able to map out a harm reduction service or intervention that is going to be friendly and appropriate for GBMSM, trans and non-binary people engaged in chemsex.

In case you have sent a questionnaire via email (see before the training section above), you may present what the participants have asked for before presenting the goals yourself, or have their requests embedded in your goals.

Alternatively, you may ask them to write up to three things (giving them approximately 5 minutes) they expect from this training in small pieces of paper, gather them and contrast them with the presentation of the goals above and discuss whether they are to be covered, if they can be added in the course's goals or, if not, why etc. If facilitating this activity, the trainer should keep in mind that the time available for this conversation will be extremely limited and keep it to the point.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

7.2.2. WHAT IS CHEMSEX

SESSION'S GOALS

- Introduce substance use in a context that is not stigmatising.
- Be able to understand chemsex as a specific kind of sexualised drug use.
- Be informed about the particular context of chemsex (polydrug use, multiple partners, prolonged sexual activities, extended apps use).
- Understand the goals, risks and other factors associated with chemsex (minority stress, internalised homophobia, etc.).
- Understand the association of chemsex with sexual health.
- Understand that not all GBMSM, trans and non-binary people using psychoactive substances are engaged in chemsex.
- Understand that not all GBMSM, trans and non-binary people engaged in chemsex do so in a problematic way.
- Be aware of signs that signify the probability of problematic chemsex involvement.

SESSION'S IMPLEMENTATION

At this point, the trainer may present a number of PowerPoint slides and discuss them with the participants of the training.

INTRODUCTION IN BRIEF

Substance use and society: an introduction

- Psychoactive substance use is common in almost all historical, cultural and societal contexts.
- Substance use is stigmatised.
- People involved in it who face problems are marginalised.
- Accessing care and support is challenging.
- Harm reduction is a better alternative to traditional addiction treatment perspectives:
  - It aims at minimising the risks involved with psychoactive substance use in collaboration with the beneficiaries and their individual needs.
  - It is *'working with people without judgement, coercion, discrimination, or requiring that people stop using drugs as a precondition of support'*.
  - It takes into consideration the intersectionality of the identities and experiences of its beneficiaries, something crucial when working with LGBTQI+ people and other stigmatised populations.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

CHEMSEX: MORE THAN SEX AND DRUG

WHAT IS CHEMSEX?

- Sexualised drug use is the use of any legal or illegal psychoactive substance before or during sex.
  - It is more frequent among LGBTQI+ people (non-heteronormative connection, minority stress etc.).
- Chemsex (or Party and Play) is a specific kind of sexualised drug use:
  - Chemsex is the voluntary use of specific psychoactive substances, referred to as chems, among GBMSM, trans and non-binary people.
  - The purpose of chemsex is to enhance, prolong and disinhibit the sexual experience, as well as to explore and process queer sexuality.
  - Chemsex commonly involves:
    - ◊ Multiple partners.
    - ◊ Prolonged sexual activities that may last from hours to days.
    - ◊ Extensive use of dating apps.
    - ◊ Combination of psychoactive substances.
  - Chemsex involvement entails the risk of dependence, overdose, sexual health and other biopsychosocial issues

THE SUBSTANCES MOST USED IN CHEMSEX

- Crystal methamphetamine.
- GHB/GBL (gamma-hydroxybutyrate / gamma-butyrolactone).
- Cathinones (mephedrone, 3MMC, 4MMC).
- Often combined with each other as well as with ketamine, cocaine, alcohol, erectile dysfunction drugs, MDMA, amyl-nitrates (poppers), antidepressants and other substances.
- Substance preferences, lifetime rates and means of use vary across different cities, countries, cultures, policies and other factors. There is very little data (if any) on trans or non-binary people.

At this point, before presenting the next slide, the trainer may decide to perform a little brainstorming task with the group of trainees and ask them what they think about the factors associated with the chemsex phenomenon, which is specifically encountered among GBMSM, trans and non-binary people. The trainer may use a board to write the answers and discuss them in combination with the content of the following slide. They must be careful not to be judgmental regarding any stereotypes and misconceptions that may emerge during the brainstorming. The aim here is to make those very misconceptions visible, provide a more accurate perspective and make space for the participants to reflect on their perceptions. However, the trainer must also be prepared to mediate, if another participant feels offended or hurt by what is said, and de-escalate the situation, while respecting the feelings of everyone involved.

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

WHY IS CHEMSEX? - POSITION PAPER OF THE 2ND EUROPEAN CHEMSEX FORUM (MARCH 2018)

Chemsex connects uniquely to gay sex, in the context of how the enjoyment of gay sex has been affected by:

- Societal attitudes toward LGBTQ+ people and gay sex.
- The trauma the HIV/AIDS epidemic has had on LGBTQ+ people and on gay sex.
- Chronic bullying of LGBTQ+ people.
- Both explicit and more covert peer pressure amongst gay men.
- The importance of shared ritualised activities in a stigmatised group.
- Community tensions about masc/fem behaviours (or self-identities) particularly in regard to the enjoyment of sex and sexual fantasies.
- Gay hook-up technologies and saunas.
- The widespread availability of chems to gay men and trans and non-binary people via gay hook-up apps.
- The reality that GBMSM, trans and non-binary people engaging in chemsex can also be sex workers, racial and ethnic minorities, migrants and/or prisoners. They may also have mental health diagnoses, other addictive disorders, disabilities, be living with HIV and/or HCV, or out of the workforce.
- The current trauma of so many lost gay men, trans and non-binary people as a result of chemsex.

CHEMSEX AND SEXUAL HEALTH

- There is evidence that chemsex is a risk factor for HIV and other sexually and blood borne infections transmission.
- Effect of substances in decision making about safer sex practices.
- Multiple partners.
- Slamming (intravenous use) and using shared equipment.
- Chemsex is more common among GBMSM living with HIV.
- However, the association of chemsex engagement with HIV is complicated and no clear causal relationships between them have been established.
- The association of HIV with chemsex is strongly affected by the trauma of the AIDS pandemic and the stigma faced by the LGBTQI+ community.
- The association of HIV and chemsex involvement has contributed to compounded stigma suffered by those living with HIV and being engaged with chemsex!

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

PROBLEMATIC CHEMSEX

- Not all GBMSM, trans and non-binary people using substances are involved with chemsex.
- Not all people involved with chemsex do so in a problematic way.
- There is no clear definition regarding problematic chemsex engagement:
  - Problematic engagement is often highly subjective.
  - Not all problems deriving from problematic chemsex are equally severe.
  - Not always perceived as such by people facing it.

THE PROBLEMATIC CHEMSEX JOURNEY; A FRAMEWORK (PLATTEAU ET AL. 2019)

- Life history (Adverse childhood, gay history, syndemics, HIV / AIDS).
- Loneliness and emptiness leading to inhibition.
- Search for connection (e.g. through social media and dating apps).
- Sexual connection probably assisted through substances.
- Chemsex connection; strong, although may become the sole source of pleasure and connection.
- Problematic chemsex; loss of job, STI transmission, intersection with forced transactional sex, mental health issues.

SIGNS OF PROBLEMATIC CHEMSEX

- Difficulty in having sober sex, sometimes underpinned by the fact that the last time one has had sober sex was a long time ago.
- Difficulty in enjoying things and activities enjoyed before.
- Difficulty in finding something new that looks interesting.
- Difficulty in finding motivation to do things other than chemsex.
- Chemsex involvement systematically lasts longer than planned.
- There are systematically lost hours or even days from work or other important activities.
- Time with friends, family or other people not involved in chemsex is diminishing.
- Weekend party and play is the sole motivation throughout the week.
- Mental health issues are emerging (gradually becoming more intense and long-lasting).
- Sadness, anhedonia, irritability, undue anxiety, intense suspiciousness, emotional outbursts, social anxiety, psychotic symptoms etc.

KEY POINTS FOR SESSION II

- Make sure the trainees understand that chemsex is not just using drugs in a sexual context.
- Elaborate on the factors that are related to chemsex (pleasure, connection, hook-up culture, coping with minority stress and other adverse events impact) making clear that it is not pathological in and of itself.
- Make clear that working with chemsex is working with the challenges faced by GBMSM, trans and non-binary people.
- Make clear that the impact of substance use stigma, compounded with other stigmas, is one of the most harmful factors associated with chemsex engagement.
- Elaborate critically on the intersection of HIV and chemsex.
- Make clear that there are no diagnostic criteria for problematic chemsex - the trainees should understand that problematic involvement must be discerned on an individual basis.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

7.2.3. THE SUBSTANCES OF CHEMSEX

SESSION'S GOALS

- Learn what the chems are.
- Learn their effects, means of use and potential negative effects of their use.
- Learn the harm reduction guidelines for each substance.

SESSION IMPLEMENTATION

At this point, the trainer may proceed with the presentation of the chems - probably after a small break that followed the previous session.

OPTIONAL ACTIVITY: STUDY GROUPS

Instead of the trainer presenting everything in this session, it might be a good idea to divide participants into five groups, one for each of the substances discussed in this manual. The groups have a set amount of time to each read up on one substance (approximately 20 minutes). The reading material can be provided by the trainer, and can be the corresponding pages in the first part of this manual. The group can also be given access to the slides on the substance they are working on. In the time they have, they will read the material and prepare a presentation using the slides (or embellishing on them, if that feels right). During this time, the trainer will be monitoring all groups and be available for any questions they might have or support they might need. It will be a good idea for each group to rehearse their presentation in front of the trainer, to boost their confidence and eliminate any misunderstandings that may have emerged regarding the material (another 20 minutes for rehearsing). In the end, each group will present their work to the others (30 minutes for the presentations). Questions by the audience should be answered by the trainer at this point.

This activity requires a fairly high level of efficiency and trust, both within and between the groups. It will not be suitable for everyone, but it may be very useful when training people who have already established good rapport and working relationships prior to this training. On the other hand, if it is deemed to be appropriate and works well, it can be a good stepping stone towards the higher level of independent work required for Session IV.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

GETTING ACQUAINTED WITH THE CHEMS; EFFECTS AND HARM REDUCTION

CRYSTAL METHAMPHETAMINE [SUB-SECTION HEADER]

THE BASICS

- Potent psychostimulant substance.
- Comes in powder or crystals to be ground.
- Street names; meth, speed, ice, Tina, crystal, tweak, crank, and glass.
- Means of use:
  - Smoked (with a glass pipe).
  - Injected intravenously (slammed).
  - Inserted rectally (booty bump).
  - Snorted.
  - Ingested orally, in some cases wrapped in a piece of paper to prolong digestion (bombing).

EFFECTS

- Higher heart rate, blood pressure and temperature.
- Excessive sweating, rapid shallow breathing, and pupil dilation.
- Increase of sexual desire.
- Strong sense of euphoria.
- Confidence.
- Appetite loss and less need to sleep.
- Increase of energy, curiosity, and alertness.
- Decrease of anxiety.

DANGEROUS EFFECTS (IN CASE OF OVERDOSE)

- Hypertension
- Chest pains
- Heart failure
- Arrhythmia
- Breathing difficulty
- High body temperature
- Paranoia
- Severe stomach pain
- Unresponsiveness and coma
- Intracranial haemorrhage
- Seizures
- Ischemic stroke
- Erectile dysfunction ("crystal dick")
- Comedown: anxiety, depression, tiredness and headaches

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

LONG-TERM USE CONSEQUENCES

- dental decay
- weight loss
- Skin picking, scabs
- Agitation and mood swings
- Tolerance: built rapidly and leading to higher doses and use that is more frequent
- Psychosis, paranoia, delusions, hallucinations
- Repeated (sexually transmitted, bloodborne, skin) infections
- Insomnia
- Persistent neuropsychological issues (alterations in executive function, episodic memory, psychomotor functions and information processing)
- Withdrawal symptoms: depression, irritability, anhedonia, attention deficit, self-medicating through further use

- Medications for psychosis and blood pressure can be less effective if crystal methamphetamine is used.
- Other substances (e.g. ecstasy, cocaine, poppers and erectile dysfunction drugs): blood pressure dysregulation, heart attack or stroke.

HARM REDUCTION

Nutrition of quality before partying. High fat food protects from the harmful effects of oral uptake.

Taking breaks to avoid physical exhaustion, hydrating (water, juices, electrolytes preferred), having a snack and a shower

Tooth brushing, using sugar free chewing gum and hydrating will protect the teeth

Condom change every 30 minutes. Water-based lubricants are preferable

Taking smaller doses at longer time intervals

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

COMEDOWN RECOVERY

- Nutritious food consumption (high quality protein, a lot of non-alcoholic liquid).
- Calcium, magnesium and multivitamin food supplements.
- Sleep replenishment - quiet and safe environment. (Prolonged lack of sleep may cause severe cognitive deficits and hallucinations.)
- Keeping contact with trusted and non-judgemental people and having quality time not connected with substance use.
- If the comedowns are getting particularly overwhelming, reduce the frequency of substance use and/or the amount used or have a break altogether.
- If withdrawal symptoms are not receding or getting difficult to control, seek support.
- Take care of skin damage.

METH INDUCED PSYCHOSIS

- Common occurrence manifesting with paranoid ideation, ideas of being followed or surveilled etc., acoustic and tactile hallucinations and confusion.
- More probable in cases of dependence, regular use, or overdose, as well as lack of sleep.
- In most cases, symptoms will stop by ceasing substance use and having proper self-care (e.g. sleep, nutrition, relaxation).
- If symptoms persist, long-term abstinence and professional support are recommended.
- If symptoms manifest during a chemsex party, take a break and seek the company of a trusted partner or partners.

[30]*Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

GBL (GAMMA-BUTYROLACTONE)/GHB (GAMMA-HYDROXYBUTYRATE)

THE BASICS

- Central nervous system depressant - in small doses it also acts as a stimulant.
- Transparent, slightly salty, odourless liquid and more rarely as a white powder sometimes enclosed in capsules.
- Street names: G, Gina, Geebs, Liquid Ecstasy, Liquid X, Liquid G, Goop, Georgia Home Boy, Easy Lay, Soap.
- Means of use:
    - Ingested (often mixed with juice).
    - Taken rectally.
    - Injected (not often).
- Effects start 10 to 30 minutes after uptake, last about 4 hours (depending on body weight and tolerance).
    - G is rather rapidly metabolised, so it can only be detected in the blood for 8 hours after use and for 12 hours in urine.
- GHB (often sold in powder or capsules) is the substance that is produced in the body when GBL is taken. GBL has a stronger effect than GHB, but it lasts for a shorter time.

EFFECTS, MODERATE DOSES

- Euphoria
- Sociability
- Sexual arousal
- Relaxation
- Drowsiness
- Lack of inhibition

EFFECTS, OVERDOSE

- Dizziness
- Nausea
- Tremors
- Confusion
- Irritation and agitation
- Loss of coordination
- Hallucinations
- Memory lapses
- Seizures
- Coma - G-hole (loss of consciousness and slumber that can last from minutes to hours - danger of respiratory arrest or heart failure).
- G-hole precursors: confusion, incoherent speech or involuntary muscle contractions
- Respiratory arrest and death

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

LONG-TERM USE CONSEQUENCES

Psychological and physical dependence:

- Occurs quickly, even after three consecutive days of use.

Withdrawal symptoms begin 2 to 3 hours after the last dose and can last up to 12 hours:

- Anxiety, tremors, insomnia, vomiting, high blood pressure, tachycardia, confusion and hallucinations, though in severe conditions hyperactivity, paranoia, psychosis, seizures or even death.

Repeated comas can cause problems in memory function and emotion regulation.

MIXING SUBSTANCES

- Depressants (alcohol, ketamine, opiates, benzodiazepines etc.): highly dangerous, even fatal.
- Stimulants: also dangerous for overdose and increases the probability of paranoia, hallucinations and aggression.
- Poppers or erectile dysfunction drugs: may cause cardiac arrest.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

HARM REDUCTION

Mixing G with other substances should be avoided

Caution not to confuse GHB and GBL

Start with smaller doses and wait to check if the dose taken was sufficient

G is safely stored in bottles not used for other liquids

In cases of dependence, it is better to gradually reduce the dose one takes or seek medical help

Signs of G overdose: sweating, vomiting, irregular or shallow breathing, being unable to stand, involuntary muscle contractions and G-hole

Drinking G straight from the bottle should be avoided

Should be avoided if blood pressure problems, seizures, respiratory problems, depression or panic disorder exist

Continuous use for over 6 hours should be avoided

Doses should be decided on and checked by the person taking them

Check your drinks and use your own lubricants to avoid spiking

In the presence of severe withdrawal symptoms, refer to a hospital emergency department

Take care of consent issues; use in safe environments and ensure consent when having sex with partners on G

Have a way to tell cups apart during a chemsex party

The source providing G should be trustworthy

G should be diluted in water, juice or other non-alcoholic drinks

Syringes (or other lab tools that can accurately measure ml) are the best way to measure the quantity to be taken

Wait at least two hours before the next dose, in order to avoid overdose

- Each dose of G is recommended to be smaller than the previous one
- Keep a record of when each dose was taken

In case of G-hole:

- *Make sure that the person in a coma lies on recovery position.*
- *Keep an eye on them.*
- *Call for an ambulance, if not sure whether a partner has fallen into a coma. (in case of medical staff involvement, be honest about what caused the symptoms/coma).*
- *Avoid using other substances (e.g. stimulants) to wake up the person in G-hole.*

MEPHEDRONE (SYNTHETIC CATHINONES)

THE BASICS

- Psychostimulant substance with some hallucinatory effects.
- Comes as a fine white powder, in an off-white or yellow crystal-like form that can be broken down into powder, or as a mustard- or custard-coloured cream.
- Street names; Meph, 4MMC, Kitty Cat, M-Cat, Food Plant, Bubbles, Crubs, Meow-Meow and Drone.
- Means of use:
  - Snorting
  - Swallowing (bombing)
  - Slammed,
  - In pills or capsules
  - Smoked
  - Rectally (booty bump)

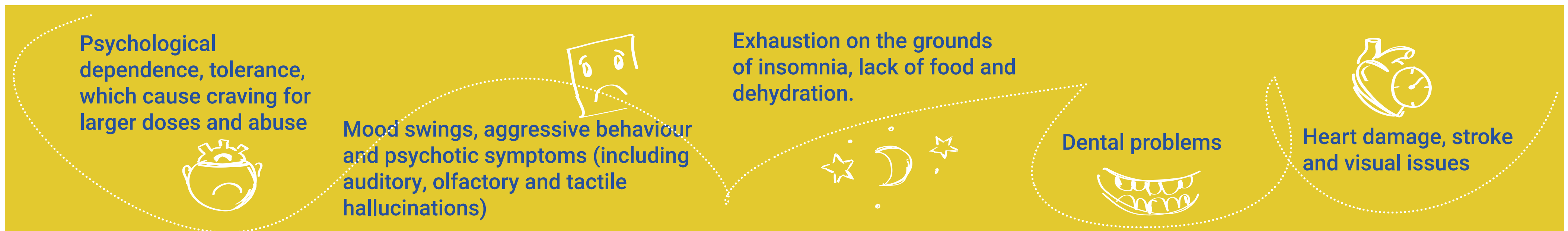
EFFECTS

- Euphoria
- Alertness
- Confidence
- Sexual arousal and focus as well as affectionate emotions
- Sense of connection to others
- High attention, sometimes becoming obsessive

POTENTIALLY HARMFUL EFFECTS

- Dehydration
- Teeth grinding and jaw clenching
- Changes in body temperature
- Muscle twitching
- Vertigo
- Headaches
- Changes in blood pressure
- Pain and injuries in throat and nose.
- Anxiety
- Hypervigilance
- Dizziness
- Paranoia
- Craving to redose
- Loss of short term memory
- Insomnia
- Overdose: convulsions, tachycardia, fever, heart attack

LONG TERM CONSEQUENCE



[30]*Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

MIXING SUBSTANCES

- Psychiatric medication (in particular some anti-depressants): may be very dangerous.
- Psychoactive substances, especially other psychostimulants: increases the probability of dangerously high blood pressure and body temperature.
- CNS depressants: may lead to overdose from either substance.
- Alcohol: should be avoided.

HARM REDUCTION

Start low and go slow

- Snorting is best limited to once every 20 minutes and swallowing to once every 40 minutes at most

Rinse the nose and mouth after each use

In case of overheating, find a quiet and safe place to have a break. May also be useful to remove some clothes or lower the body temperature by drinking cold water and taking a shower.

Wear sunglasses in order to protect the eyes from the pupil dilation that mephedrone causes

Weighing doses - doses over 80mg are very dangerous

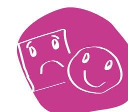
Eat nutritious food and drink water (or other non-alcoholic and low sugar beverages).

Sharing use equipment should be avoided

Partying for over one to two consecutive days is quite dangerous

The least harmful way to use mephedrone is orally

- Snorting may cause nasal damage, inflammation and bleeding
- Slamming can cause unpleasant side effects, vein and skin damage, blood borne infections and severe overdosing.
- Smoking increases the probability of craving for redose. Do not smoke more frequently than every half hour.



In case of overdose, put in recovery position, if unconscious or keep relaxed and safe

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

KETAMINE

THE BASICS

- Anaesthetic, analgetic, antidepressant, anti-inflammatory and psychoactive (depressant and hallucinatory) effects.
- Often used together with other chems.
- It comes as a colourless, odourless and tasteless liquid and, more frequently, as a white powder or tablets.
- Street names; K, Special K, Vitamin K, Ket, bump of K, Kiddy/Techno smack.
- Means of use:
  - Mixed with drinks
  - Snorted (sometimes with the use of bullet shells)
  - Swallowed (bombing)
  - Mixed with water and injected into the muscles
  - Delivered rectally (booty bumps)

EFFECTS

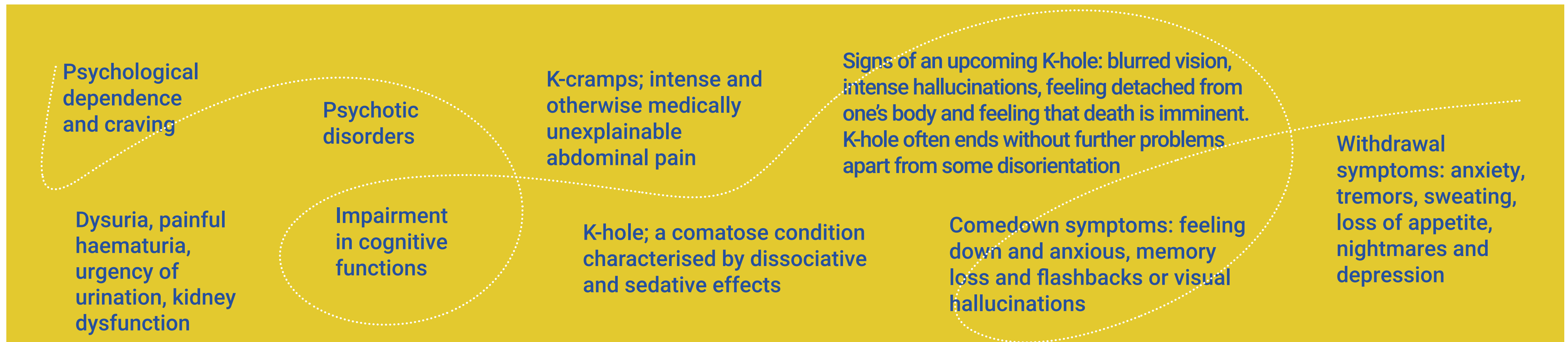
- Feeling of floating
- Detachment and muscle relaxation
- Sense of euphoria
- Happiness and peacefulness
- Sexual arousal and disinhibition
- Dysfunction of the urinary tract
- Difficulties in erection and ejaculation
- Dizziness, nausea and vomiting
- Ataxia
- Nasal irritation
- Extreme dissociation
- Panic attacks
- Bad trips with frightening hallucinatory experiences

MIXING SUBSTANCES

- Mixing with depressants may result in severe respiratory and heart dysfunction.
- Mixing with crystal methamphetamine, cocaine, and ecstasy may cause harmful heartbeat increase, confusion and risk of injury.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

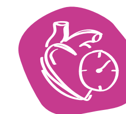
LONG-TERM USE CONSEQUENCES



HARM REDUCTION

Be careful not to confuse ketamine with any other powders or tablets

Start low and go slow


Avoid using if facing mental health, heart, liver, or blood pressure issues

Combining ketamine with depressants and psychostimulants should be avoided

Smoking when on ketamine use may be dangerous for fires or burns

Injecting ketamine is dangerous - injecting in the veins should be avoided

Ketamine's pain relieving properties entail the danger of internal injuries during sex that may not be realised on time

Prefer use in the presence of trusted company

In the case of K-hole; move the person somewhere quiet with no bright lights and call the ambulance if they do not wake up - be vigilant for respiratory difficulties

If used in order to experience a K-hole, make sure the environment is safe and lie down at a place where you will not fall and hurt yourself

When dealing with medical staff in cases of overdose, be honest in order to receive the proper treatment. Inform the physician about use when scheduling a planned surgery

[30]*Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

COCAINE

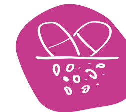
MIXING WITH PRESCRIBED MEDICATION AND OTHER SUBSTANCES

- Antidepressants that affect serotonin brain function: may be very dangerous.
- Benzodiazepines: may lead to an overdose.
- Paracetamol: may increase the adverse effects of cocaine on the liver.
- Evidence that systematic cocaine use may decrease antiretroviral effectiveness.
- Mildly blocks the effect of amphetamines and other psychostimulants and increases the risk of stroke or heart failure.
- G: may cause serious respiratory problems or overdose.
- Ketamine ("Calvin Klein"): may dangerously increase ketamine's toxicity in the body.
- Alcohol: the mixture produces cocaethylene in the body. That is harmful for the heart and liver, and may even cause death.

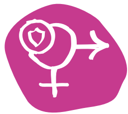
HARM REDUCTION

Test for adulteration before use

Start low and go slow

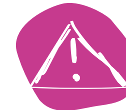


Grind to very thin powder



Consider safer sex beforehand due to the impulsiveness induced by cocaine.

Take short breaks during sex in order to check out that everything is OK (injuries, broken condoms etc.)



Signs of overdose: seizures, confusion, tremors, respiratory problems, nausea and vomiting, tachycardia, high body temperature, paranoia and hallucinations, and panic attacks

Avoid cocaine if facing heart, respiratory, liver, kidney, seizure or psychiatric issues

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

KEY POINTS FOR SESSION III

- Be informed about the chems, their street names and means of use.
- Be able to describe their desired effects by people using them.
- Be able to describe the undesirable effects or the harmful side effects of their use.
- Be informed about long-term use or abuse risks for each substance, in order both to address them but also to be aware of signs of abuse encountered at the beneficiaries who may not have realised a probable loss of control.
- Be informed about the harm reduction and first aid regarding the use of each substance.

At this point, the trainer might consider having a break (if they hadn't already) before proceeding to the next session. If you are having a two-day course, this is probably a fine time to end the first day's part. In such a case, it is useful that the trainer takes some time before breaking the meeting for the day in order to check in with the participants. This may easily be done by asking them to tell a phrase, a word or an emotion with which they are leaving that day's training session. The trainer may use the ball technique (see introduction activity) to make the first part closure more interactive.

Walking Gallery. There is another useful and probably fun activity to consider at this point, before closing the session, especially in case the study group activity has not been used. The table below has a selection of characteristics and effects for each of the three main chemsex substances. To facilitate this activity, the trainer needs to print and cut the individual cells of the table, or to write them in small pieces of paper or post-it notes, before the session.

When the time for the walking gallery arrives, the trainees are split into groups and each group is assigned one substance to work on and a part of the room. [Note: If the study groups activity has been used, the groups can be the same, with the trainees that have been working on cocaine and ketamine divided into the other three. However, in this case, it is of paramount importance that all groups work on a substance that is different to the one they have already focused on.]

The trainer then can either scatter the little papers in the room, or leave them all inside a hat for trainees to sort out. Each group has to find their own papers (i.e. the ones that correspond to the substance the group has been assigned) and put them on display in their own area.

It is suggested that, at this stage, the trainer does not give trainees any help or answer any questions. In fact, they can leave the room, if that feels necessary. The aim of the activity is to give trainees the opportunity to consolidate their understanding of the concepts that have been discussed, revise their notes, if necessary, and foster rapport by allowing collaboration and knowledge exchange. For this reason, it is of paramount importance that this activity (just like all the activities suggested here) is not framed as a competition between the groups, but rather a collaboration: you 'win' the game only if all substances have all the characteristics that they should.

When the trainer returns to the room (if they have left in the meantime) to take a stroll down the walking gallery, it might be a good idea to ask trainees questions regarding their choices. This should take place in a friendly, informal, chatty manner.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

CRYSTAL METHAMPHETAMINE	GBL/GHB	MEPHEDRONE
Tina	Gina	Mew-Mew
Slamming	Slamming	Slamming
Powder / Crystals	Liquid	Powder / Cream
Strong sexual desire and euphoria	Relaxation	Euphoria and connection
Appetite loss	Dizziness	Teeth grinding
Paranoia	G-hole	Paranoia
Psychosis	Respiratory arrest during coma	Hallucinations
Teeth problems	Easy to overdose	Teeth problems
Persistent neuropsychological issues	Physical dependence	Craving larger doses
Sweating	Uncertain Consent	Overheating

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

7.2.4. MANAGING RISKS OF CHEMSEX INVOLVEMENT

SESSION'S GOALS

- Be aware of areas in the chemsex engagement overall that entail risks.
- Be aware of means to reduce the potential harms entailed by these risks.
- Be able to understand the prevention or harm reduction of risks entailed by chemsex engagement on temporal terms so that to tailor harm reduction according to these terms.
- Be able to discern what parts of chemsex involvement might entail risks for a specific beneficiary in order to deliver person-oriented intervention and empowerment.
- Be ready to address several issues that can emerge from chemsex engagement.

SESSION IMPLEMENTATION

This is a fine part for the trainer to make the training quite interactive. Actually, if the third session has been based quite a lot on lecture and information providing, the trainee group will welcome the chance to be more actively involved, and reflect on chemsex and harm reduction by thinking constructively and exchanging opinions and ideas.

For this reason, at this part, we propose **an activity in small groups**. In case the trainer decides to implement it (as described below), they may make the **presentation** of this session after the activity, mostly in the context of the discussion that will follow the small group activity, e.g. by adding ideas that were not brought forth by the trainees, based on the examples of the activity, as well as a to wrap up the session. In case the trainer or the course participants do not find implementing the activity appropriate for their training, the course may proceed with the presentation and its discussion only.

WORKING IN SMALL GROUPS CASES ACTIVITY

This activity aims for the trainees to better understand chemsex involvement and reflect on harm reduction using some fictional cases, which are based on real beneficiaries. The trainees have to imagine that each case example is a beneficiary they are meeting for the first time in the service they work in. The activity will help the trainees to:

(i) have an idea of realistic cases of different chemsex engagement,

(ii) think of harm reduction in a holistic approach (dealing with substance use but also with sexual health, self-care etc.),

(iii) exchange ideas and points of views with colleagues, and

(iv) reflect on their own emotional reactions, counter-transference and blind spots as triggered by the material of the cases.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

This way the material of this session will emerge with a combination of the group process and the information the trainer provides at the end. The participants have to be informed that the cases are provisional examples and in real life harm reduction counselling, of course, things may be different - they are to consider this material rather as a stimulus to reflect on. It might also be advisable to inform participants that the real people those cases are based on did actually benefit from the care they received and are doing better.

This activity may also be done with participants working individually, but this decision will not give them the opportunity for the participants to discuss.

If the training group is very small (fewer than six participants), there would be one group only, the participants will not be split up.

STEP 1: Split the trainees into small groups. Groups of four are ideal but, if needed, groups of three or five will be fine. Avoid having groups of six or more participants.

Groups are best to be formed at random, so that each participant will have to collaborate with people they do not already know. This can be done in various ways - one example is the count off. Number off each participant according to the number of groups you are going to have. 1s are a group, 2s are a group, and so on.
Encourage the small groups to spread around the training venue in order to have some privacy, but monitor them discreetly and be available in case there are any questions.

STEP 2: Give each small group all three cases (presented below). This may be done by having them printed or shared via email, to be accessed by their cell phone. However, the printed version is more useful in order to be able to keep written notes next to the cases. Paper should be readily available, should participants need it.

STEP 3: Give each group the following questions (again, either printed or shared by email) for each case example. Each group will discuss the questions, and their thoughts will then be shared with the other groups.

1. What kind(s) of harm is each case example facing or at risk to face?
2. Do you think chemsex engagement of each case example to be problematic?
   a. Why?
   b. If yes, at which part of the problematic journey do you think they are?
3. What harm reduction and prevention measures would you recommend? Organise them regarding the temporal moment they would best apply (before, during and after chemsex involvement).
4. What do you think would be difficult for you in working with each case example?
5. What's your personal emotional reaction regarding each case example?

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

Give the small groups enough time to work with each case example (about 1 hour and not less than 45 minutes), before they return. Also consider having a small break (e.g. 5 minutes) before returning.

STEP 4: Have each small group present their answers to the rest of the training participants. Avoid discussion among the groups at this point and make sure each group will have enough time to present their conclusions and questions that might have emerged. Keep notes on each answer and perhaps write the main points of harm reduction and prevention on a board (flipchart or otherwise) divided in 'before', 'during' and 'after' to be seen by the whole group. If practical, these points can even be written by the participants themselves. This will be easier with smaller groups and in smaller venues.

STEP 5: After all groups have presented their conclusions, discuss them and add anything that they had not thought of (at the end of each case example there are some key points provided that connect them with the presentation of this session). At this point, the trainees may discuss among themselves and the trainer, of course.

Keep an eye out for disagreements that may escalate. The participants' emotions, stereotypes or personal experiences can trigger intense arguments. Help to refocus through pointing out that internal conflict is often an issue that makes receiving help difficult for our beneficiaries to receive help and manage the issues and challenges they face. This conflict manifests, of course, in the context of the training and helps us empathise with their experiences, as well as productively think of how to integrate different opinions and approaches in each beneficiary's best interest. Do not forget to remind participants that some cases could concern people having a problematic engagement with chemsex at the moment and by no means all people involved in it face problems. The fact is that most people that will look for our help will be most probably facing issues with their use. The ones that have it under control, on the other hand, are less likely to visit us. These cases are just exercises and by no means representing the whole population engaging with chemsex.

STEP 6: Give the presentation provided below (in blue) as some means of wrapping up this session. Try to refer back to the cases that the participants have been working on as much as possible. That will be easier if their ideas are visible on the board.

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

CASE EXAMPLE 1

Jordan is a pleasant and polite 21-year-old cis man. He recently moved to your city because he's studying here. When he arrived, he came out. He feels really good about that. In his hometown things were 'pretty shit'. He comes to you because he is considering experimenting with substances and sex and it's 'bugging him a bit'.

He's been in a relationship with a guy close to his own age for a couple of months now. A week ago, he and his partner decided to 'play' with another couple of 'older guys', around 30, whom they met via Scruff. When they went to their place, the atmosphere was 'pretty hot' though the other couple was acting a bit 'weird'. They offered them something that they poured in their juice, they all drank together and it was great. The next day they had intense headaches and felt a bit dizzy, although they 'had had chemsex before, as they use poppers'. What is troubling Jordan is that, during the 'fun', they didn't use condoms all the time.

His boyfriend doesn't seem to be worried because the other couple told them they're 'on TASP'. Jordan didn't understand what that was, but was too embarrassed to ask. He also mentions that they've been invited next weekend to go to their house again. This time there will be other people there too and they'll all have a good time together. Jordan wants to go but he's 'a bit worried'.

KEY POINTS

- Refer to the presentation of this section as well as the previous one (especially regarding G) and make sure each point (before, during and after, as well as safer G use) is addressed.
- Keep in mind to point out for the trainees not to rush to persuade the beneficiary not to experiment or avoid going etc., as it seems quite probable that he will go anyway. It is more important to have a strong working collaboration, address harm reduction for both substance and sexual health (for example PrEP use) and be at his disposal in case something unpleasant happens.
- Point out the importance of issues such as harsh treatment in Jordan's years as a minor, the challenges presented regarding coming out and the fact that, at this point, he may be very excited about his new life and the opportunities that are opening up before him may make him a little compulsive. These issues will be partially addressed in the next section of the training.

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

CASE EXAMPLE 2

Morgan is quite sweaty and extremely tense. He speaks loudly and asks you whether there are cameras recording in the room - he tells you that he is not sure but has had such a feeling from the time he entered your service. Immediately after he greets you he begins, before even sitting down, to speak with a train of thought that you find rather confusing. He is mad at a client of his who asked him to go get tested for HIV and consider visiting a mental health professional, "like he was crazy".

Regarding this client, he says: "I know Henry wants to take care of me and he's worried about my well-being. I stay at his place sometimes but he is 50-year-old and I am a professional and I'm still very young, 31, and want to do my thing. I felt insulted when he asked me to get tested like I was a slut. Henry is important to me, I never met my father".

Morgan also tells you that he uses Tina but keeps it under control. He is insulted that his friends and clients don't want to hang out with him any more as if he was a "junkie". Sometimes, he's sure that his friends and clients keep secretly in touch among themselves, they discuss him and are planning to send him to a psychiatric clinic. He has other friends though with whom he hangs out and plays and they understand him, being in the same mood. At this point, he shows you his arms and tells you that he has some skin problems and wounds. Indeed, you see some areas are swollen and profoundly damaged.

He continues that he slammed this morning, in order to be in a good mood on his way to meet you. He's only top with his clients but likes bottoming as well when he slams. Answering your questions regarding his use, he informs you that he hasn't had sober sex the past two years. Along with Tina, he uses G, Viagra and, during comedowns, antidepressants.

KEY POINTS

- Refer to the presentation of this section as well as the previous one (especially regarding crystal meth and its interactions with other substances) and make sure each point (before, during and after, as well as safer crystal meth use and dealing with crystal meth induced psychosis) is addressed.
- This is a case of rather problematic use and active crystal meth induced psychosis. There is a lot to be addressed, of course. The important point is to prioritise (based on what is most urgently needed but also what is feasible). At this stage, the most crucial steps are to make the beneficiary feel safe and earn their trust in an honest way. Then it is important to collaborate with the beneficiary and set goals together, rather than imposing our own ideas, priorities or beliefs on them. After having established a strong working alliance, refer Morgan to a physician to attend to his sexual health and probable damage caused by injecting as well as a mental health professional.
- Point out the importance of the intersectionality with the sex worker profession and the fact that harm reduction also applies there. Referring Morgan to a sex worker organisation would probably be helpful too.

[30]*Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

CASE EXAMPLE 3

Eric is a 51-year-old cis man. He is very thin, with dark circles under his eyes and seems rather tired.

He has come to visit you in order to address issues with substance use. He visited a rehab service but it took them very long to give him an appointment and, when he did go to a meeting there, he felt they couldn't understand him as they referred him to a program for heroin users which included group sessions in which he felt the odd one out.

Despite his face not exhibiting much emotion, he admits that he is very worried. The last four years he has been slamming and snorting mephedrone, and sometimes he has combined his use with MDMA and ketamine and occasionally he has ingested and booty bumped G. He used to hold chemsex parties at his place but now people "freak him out", since a laptop was stolen from his house. He now uses on his own, watching porn or, sometimes, he calls a trusted friend to get fisted.

He is financially well off, with an income from houses he rents out so, as he describes, he does not leave his house for long periods, staying inside with the shutters closed. He tells you that he likes using substances but he does not like the condition he finds himself in. He is disappointed in himself, due to the fact that he recently mistook ketamine for mephedrone and got paralysed for some time.

Due to this latter incident, he missed a date with a young guy who kept flirting with him through Instagram. He likes the dude but he does not know what to do; he is afraid to disclose the fact that he lives with HIV and his chemsex engagement. He misses having some company but he will turn down the boy nonetheless.

KEY POINTS

- Refer to the presentation of this section as well as the previous one (especially regarding mixing substances, slamming and booty bumping) and make sure each point (before, during and after, as well as safer substance use and dealing with G- and K-hole) is addressed.
- This is a case of a rather experienced user with some problematic aspects. Make sure to point out the need for self-care, for connection and the intersection with age and living with HIV. A referral to a mental health professional (if the beneficiary thinks it is a good idea) or some community organisation may be really helpful.
- Point out the fact that harm reduction may be, apart from planning and reducing the harmful effects of substance use, an opportunity for this beneficiary to connect, a transitional space, somehow that may help him to get empowered to form new bonds or renew old ones.

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

HARM REDUCTION IN CHEMSEX INVOLVEMENT

MANAGING RISKS OF CHEMSEX INVOLVEMENT

HARM REDUCTION BEFORE:

SELF-CARE

- Reflect on life as an LGBTQI+ subject.
- Pleasure and gratification don't exclusively come from substance use and casual sex.
- Invest more time in being creative, having a fulfilling network of people.
- A healthy lifestyle helps keep us safe.
- Dating apps use.
- Reflect on the time spent there.
- Reflect on what you look for there.
- Be respectful and kind.
- Be careful about substances purchased from unknown sources there.
- Taking time to check things out.
- Consider safety issues (e.g. regarding venues to be visited) when sober.
- Consider how safe hook-ups feel.
- Probably inform friends about your whereabouts.
- Plan the party and play ahead (quantity, with whom, how, for how long, to do what) while sober.
- Avoid using when not in a good mood, mental condition etc.
- Discuss interaction with medication taken with a trusted physician.
- If you do sex work, consider boundaries and communicate them when sober.

SEXUAL HEALTH, SUBSTANCE USE, CARING FOR EACH OTHER

- Some HIV medications have very dangerous interactions with chems. Get informed before chemsex involvement.
- Get STI tests regularly.
- Be provided with lubes and condoms before getting to a party.
- Get informed about PEP and PrEP.
- Get vaccinated (HBV, HAV, HPV, COVID-19, MPOX, meningitis).
- Get informed about harm reduction before using the substances you are about to use.
- Get clean and safe personal use equipment (straws, pipes, sterile needles etc.).
- Discuss preferences, boundaries etc. with partners before playing with them.
- Take care of personal hygiene.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

HARM REDUCTION DURING:

SELF-CARE, SEXUAL HEALTH

- Stick to the plan.
- Use logbooks to track substance kind, amount, frequency etc.
- Consider keeping the time limits set beforehand.
- Look after personal items and valuables.
- Take a break (relax, dehydrate, eat snacks, have a shower, talk to each other).
- Consider using condoms and lubes.
- Take care of sexual toys (bleach and rinse).

SUBSTANCE USE

- Look after equipment.
- Keep straws clean and change them often.
- Avoid snorting with banknotes.
- Keep intact glass pipes - consider using temperature proof mouthpieces.
- Use sterile and change injection equipment often.
- Not sharing (use equipment) is caring.
- Avoid mixing substances.
- Avoid driving, even if feeling alert.

SLAMMING

- Rapid, very intense highs BUT
- Can be very harmful.
- To avoid infection:
  - Sterilise equipment
  - Don't reuse equipment
  - Wash hands
  - Disinfect the area to be pierced with wipes
  - Dispose of equipment safely, e.g. place in plastic bottle and close the cap
- Do **not** slam in arteries!
  - Deeper than veins
  - Blood, pain
  - In case of accident: remove the needle and apply pressure with sterile equipment. If the bleeding does not stop in five minutes, get medical care immediately!
- Do not inject into the same site, if the vein can't be found immediately.
- Do not inject into hands.
- Do not inject under the waistline.
- Dilute substances in boiled water that has cooled down.
- If the skin looks damaged or is painful, seek medical help.

CARING OF EACH OTHER

- Get to party and play with trusted friends - check in on each other during the time you stay there.
- Inform about the kind and effects of substances you may offer to others (and vice versa).
- Consider using safe words to notify about (not) giving consent.
- Make the party venue safe.
- Provide condoms, disposable gloves, clean towels, disinfectant wipes or sprays, plastic bed sheets, and paper towels.
- Consider having a quiet chillout space for participants to take breaks.
- Remove grease and oil from surfaces and disinfect them often.
- If hosting, keep your valuables safe.
- If something goes wrong.
- Move to a quiet place.
- Speak, calm down, and place person, if unconscious, in recovery position.
- Do not confront if psychosis takes hold! Reassure and keep company.
- Do not make assumptions about the severity of problems occurring.
- Call an ambulance - be honest to medical/ paramedical staff.
- Kindness is sexy!

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

Harm reduction after: self-care, sexual health, getting care for each other

RELAXATION, QUALITY FOOD AND DRINK, ADEQUATE SLEEP AND, PROBABLY, FOOD SUPPLEMENTS.

CONSIDER GETTING PEP, AS SOON AS POSSIBLE, IF NEEDED.

IF LOSING CONTROL OR HAVING A BAD TIME, OR SEE SIGNS OF PROBLEMATIC ENGAGEMENT, CONSIDER GETTING HELP.

GIVE TIME FOR RECOVERY.

GET TESTED.

BE KIND TO YOURSELF! BLAMING, PUNISHING ETC. DO NOT HELP - QUITE THE OPPOSITE.

KEEP IN TOUCH, DISCUSS, BE AND KIND AND CARING.

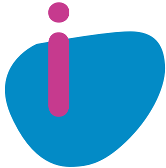
REASSESS THE PLAN (DEPARTURES, TRIGGERS ETC.).

REASSESS THE PLAN (DEPARTURES, TRIGGERS ETC.).

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

CONSENT

WHAT IS CONSENT



- Consciously say *yes*, having the right to revoke that yes at any time.
- If consent is missing, it's sexual assault.
- Discriminated people more prone to being victims of sexual assault and face more difficulties negotiating consent.
- However, when talking about sex, there are occasions where consent is not clear, not easy to give/revoke - especially when the aim is to lose control - "giving consent not to give consent".
- Chemsex sometimes is such a situation...

CONSENT AND CHEMSEX

- Even if boundaries are set beforehand, substances cloud judgement, which makes it difficult to give consent or understand whether it is given or not.
- "Yes" is not valid when "no" is difficult, scary or impossible to say.
- Sometimes, non-consensual sex involvement is realised during or after the comedown.
- The impact of such occasions may be really bad.

CONSENT AND HARM REDUCTION

Before

- make conscious decisions, communicate and discuss them.

During

- look after each other
- do not proceed if clear consent is not given, cannot be given or is doubtful (be alert for K- or G-holes).

After

- if things went wrong, discuss when ready, consider getting professional help, avoid blaming self
- Check in with partners!

KEY POINTS FOR SESSION IV

- The trainees should understand that chemsex harm reduction is more than substance use harm reduction.
- The trainees should make clear that harm reduction begins before chemsex engagement and continues after it is over, as well as have an idea of when it is better to apply which kind of harm reduction.
- Trainees should be stimulated to diverse engagements to chemsex and the potential harms that the intersectionality of experiences may entail.
- The trainees should understand the importance for them to be properly informed about sexual health issues.
- Trainees should understand that chemsex has a lot to do with connection and thus, it is important to keep this in mind when planning harm reduction interventions.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

7.2.5. BUILDING CHEMS-FRIENDLY SERVICES

This part deals with what a harm reduction provider, but also a harm reduction service, should comprise, in order to provide appropriate chemsex harm reduction to its beneficiaries. Some of those guidelines may require further training, beyond the scope of this manual. However, it is deemed important to refer to them here.

SESSION'S GOALS

- Be able to incorporate the LGBTQI+ affirmative approach into service.
- Raise awareness on power dynamics between the service provider and beneficiary.
- Raise awareness on the cultural humility perspective.
- Understand the importance of community-based and – led services, and inclusion of peers, and be to reflect on how to apply some of its guidelines.
- Be acquainted with principles of providing a service space, which is welcoming for diverse people and their needs.
- Raise awareness on some skills that may prove useful (i.e. motivational interview, psychological first aid and crisis intervention).
- Be aware of the importance of reflection and supervision of the service.

SESSION'S IMPLEMENTATION

At this point, the trainers might consider implementing an activity, which functions both as an energiser but also as stimulus to the content of this session, i.e. teamwork and reflection on best practices.

FIND SOMEONE WHO

Step 1. Ask the trainees to take some time (e.g. 2 minutes) to think of one thing, skill, knowledge, talent etc. that they are good at in their work, everyday lives, activist activities, when dealing or connecting with other people etc.

Step 2. Have them write it down on identical small pieces of paper (post-it papers should do). Step 3. Gather the pieces of paper, shuffle them and re-distribute them by chance to the rest of the participants.

Step 4. Ask the participants to walk in the training venue, mingle and find the person from the group that has the skill that is written on the piece of paper they were given, hold them by the hand or arm and stay with them until the end.

It is useful to have enough space in the training venue so that the group may move, bounce on each other etc. To make it fun, you may have some music playing and assign a quite narrow time limit to complete the investigation (5 minutes for large groups at most). It may be useful to remind the participants that they should cooperate and help each other, if some seem to be having trouble. It has to be noted that this activity is suitable for larger groups, say, of 10 or more participants.

Step 5. Having finished the activity, let a moment for the participants to reflect on a network that will have formed among the participants that will have managed to find the person they were looking for, but also any participants that may not have achieved it.

Step 6. Gather up to discuss how each participant felt during this activity, what they realised, how important they would find the skill assigned for themselves or whether they realised that some other skills, talents etc. were not written on any paper or skills that were written by more than one participant.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

ACTIVITY GOALS:

- Liven up the trainees, in case they have become tired.
- Point out the importance of teamwork and the diversity of skills that may contribute in a service providing chemsex harm reduction.
- Point out the importance of specialised but also soft skills and knowledge.
- Point out that the skills missing entail the need for further reflection, communication and investigation in a service.

Then, the trainers may proceed to the presentation of this session's content. If they have chosen to implement the activity above, it is useful not to forget to connect the skills, knowledge etc. that were discussed in the activity with the guidelines presented in this manual.

BUILDING CHEMS-FRIENDLY SERVICES

LGBTQI+ AFFIRMATIVE PRACTICE

- Providing services to non-heteronormative beneficiaries is about more than acceptance and non-stigmatising.
- It also includes affirmation of their self-determination, lived experience and challenges they face.
- It requires the providers to self-reflect on our own prejudices and stereotypes.
- LGBTQI+ affirmative practice principles (to be implemented also among the service staff);
  - Recognising and accepting the way LGBTQI+ beneficiaries identify (terminology, pronouns etc.).
  - Being aware of the complexities and challenges inherent in any kind of coming out.
  - Acknowledging the intersectionality of the beneficiaries' lived experience.
  - Being informed on important figures, symbols, historical dates and community resources.
  - Being aware of issues regarding oppression from any source and the adverse effects that minority stress entails.
  - Acknowledging the resilience that each LGBTQI+ person and community has developed and being prepared to facilitate their further empowerment.
  - Facilitating the exploration of LGBTQI+ beneficiaries' experience and identities.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

CULTURAL HUMILITY AND AWARENESS OF POWER DYNAMICS

- The power imbalance of the provider-beneficiary relationship may interfere with our practice.
- Cultural humility is about stepping down from the "expert" position and acknowledging the limits imposed by the fact that the beneficiaries' experiences are unique and not fully understandable by us.
- Be ready to learn from these experiences and collaborate according to the needs they entail.
- Be aware of the limits imposed by our own experiences, privileges etc. as service providers and the ways they may hinder our work.

COMMUNITY BASED PRACTICE; COMPONENTS

1. Focus on ecological, environmental, financial, political and social factors that hinder or facilitate well-being.
2. Respect for diversity and self-determination.
3. Investigation and action guided by principles that questions the status quo that perpetuate social injustice and discrimination.
4. Interventions focusing on systems that promote the well-being and self-regulation of systems and communities rather than individual factors and problems' prevention.

COMMUNITY BASED PRACTICE; GUIDELINES

- Participation. Include experts by experience in all aspects of its implementation: management, training, planning, delivery and assessment.
- Needs assessment. Design service according to the needs of each given particular population in the specific context in which it is going to be delivered, taking into account how those needs have been expressed by the community itself. Flexibility and readiness to change are very important, and so is following changes in the community.
- Focus on empowerment and self-management. Focus on building up resilience and self-management of beneficiaries and communities.
- Fight for change. Use any privileges and power in advocacy and policy making.

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

RECOMMENDATIONS FOR EFFECTIVE CHEMSEX HARM REDUCTION SERVICES

- Focus not only on decreasing problems but also facilitating well-being.
- Sexual health is not only the absence of issues but also the access to a fulfilling sexual life.
- Promote self-growth, self-expression and connection to communities.
- Working with our own and our beneficiaries' internalised homophobia and the impact of homonormativity is actually chemsex harm reduction.
- Be accepting and non-judgemental of practices and behaviours that are considered unconventional.
- Be present and focus collaboratively on current harm reduction needs rather than trying to persuade them that their use is problematic.
- Support and empower towards a fulfilling, meaningful, pleasurable and fun life outside of chemsex involvement.
- Chemsex harm reduction should be embedded in services that address the needs in a global/holistic manner (e.g. community-based –led sexual health clinics).
- New technologies and applications are very useful in chemsex harm reduction.
- Keep an up-to-date referral network for services that are outside of the area of harm reduction but very likely to be needed.

USEFUL CLINICAL SKILLS

MOTIVATIONAL INTERVIEW; beneficiary-centred directive method, facilitating change through resolving ambivalence by enhancing motivation.

PSYCHOLOGICAL FIRST AID, designed to be implemented mainly by non-mental health professionals aiming to empower, support and refer beneficiaries in crisis.

CRISIS INTERVENTION TRAINING; before proceeding with harm reduction or even referral of beneficiaries in crisis, the emergency issue has often to be addressed somehow - our first response may be of paramount importance.

- General guidelines (Saakvitne, 2002):

* Respect the way the beneficiary experiences the traumatic event, validate their reaction and the way they have adapted.
* Provide information about what could be expected, resources and services that could be of use.
* Provide genuine connection, presence and acceptance.

[30]*Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

SELF / TEAM REFLECTION AND SUPERVISION

- The “willingness to be disturbed” is a prerequisite for organisation, service and community sustainability.
- Unconscious beliefs and biases, as well as factors such as suppressive policies, financial problems etc., can challenge our thinking and even interfere with the way we operate in our practice.
- Supervision can be very useful to process these challenges.
- Community psychoanalysis may contribute to the well-being of the service’s community and offer insights tailored to its needs.
- Even if service providers do not wish for supervision, team reflection meetings should be systematically scheduled.
- It is important to consider each difficulty in a “binocular” vision.

ACTIVITY: MAKE YOUR OWN SERVICE.

At this point, another small group exercise could be useful.

Step 1: Divide the participants into small groups by chance (as described in the activity of session IV)

Step 2: Ask each group to plan a chemsex harm reduction service or intervention trying to incorporate as much as possible the guidelines and principles described in this session of the training and generally, from the whole course. Give them enough time (i.e. about 40 minutes).

Step 3: Gathering up, ask each group to present their service or intervention and discuss it with the entire group.

Step 4: Present some of the examples provided at the last chapter of the first part of this manual. Prefer to present examples more relevant to the cultural, political, financial etc. determinants of the trainees, as well as ones that already implement trainees’ own ideas and suggestions.

KEY POINTS FOR SESSION V

- Make sure the trainees have realised that chemsex harm reduction is more than the knowledge of some techniques etc.
- Facilitate the group in terms of understanding the importance of not only what they hear but also how they hear it, in what way they approach the material the beneficiaries bring.
- Focus on the fact that a productive service relies on not only the individual work but also the dynamics and the teamwork of all the people involved in it.
- Give opportunities for the trainees to think outside the box in planning and implementing harm reduction.

[30]Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.

7.2.6. CLOSURE

The training may end at this point. As you have just implemented such an extensive course, with a lot of new information and so many activities provided, it is important to have a closure that facilitates self-reflection and provides feedback.

FOR CLOSURE, YOU MAY USE A LAST ACTIVITY FOCUSED ON SELF-REFLECTION:

Step 1. Have the trainees be provided blank pieces of papers and ask them to think of themselves the time before beginning this training. Ask them to write down a word (probably an emotion) that signifies themselves by the beginning of the training. Give them a little time to think (maybe 2-3 minutes).

Step 2. Ask the participants to think of three things that have changed (if they changed) by the end of the training regarding (i) how they perceive chemsex, (ii) a new piece of knowledge they acquired, (iii) how they perceive themselves. Give them some time (probably up to 10 minutes).

Step 3. Ask the participants to write down an emotion, with which they leave the training. Give them another minute.

Step 4. Ask the participants to share what they have written. You may use the ball technique so that all the participants will present their reflections in a way directed by the group dynamics.

If you have used a questionnaire at the beginning to assess their knowledge, you may use it again, as feedback for the training. Otherwise, it is a good idea to distribute one trainee assessment questionnaire either printed or through a link using a platform such as Google Docs. The training assessment is useful to be anonymous, especially in cases that the trainees are known to you (e.g. if you work in the same service). Some useful questions regarding this feedback may be:

1. The overall training corresponded to my expectations.
2. The trainer had a good grasp on chemsex and harm reduction of chemsex engagement.
3. The trainer had adequate skills in transferring the content of the training.
4. The climate of the training was safe and inclusive.
5. I was given enough space to express my questions and thoughts.

For the above questions, the trainees are best to answer on a scale of 1 - Totally disagree, 2 - Rather disagree, 3 - Neither agree, nor disagree, 4 - Rather agree, 5 - Totally agree.

Consider including the following open questions, as well:

1. Which do you think was the strongest element of the training?
2. What could be improved regarding the training?

[30] *Parts that refer to energisers, self reflection experiential exercises, work in small groups etc are in pink. Parts that may be transcribed and presented on a powerpoint presentation are coloured in blue.*

Thank you

and good luck!

08

References Recommendations for further reading

CHAPTER 1 – INTRODUCTION TO SUBSTANCE USE, HARM REDUCTION AND SEXUALITY

Amaro, R. (2016). Taking chances for love? Reflections on love, risk, and harm reduction in a gay slamming subculture.
Contemporary Drug Problems, 43(3), 216–227.
https://doi.org/10.1177/0091450916658295

Benotsch, E. G., Lance, S. P., Nettles, C. D., & Koester, S. (2012). Attitudes toward methamphetamine use and HIV risk behavior in men who have sex with men: Methamphetamine attitudes.
The American Journal on Addictions, 21 Suppl 1, S35-42.
https://doi.org/10.1111/j.1521-0391.2012.00294.x

Blechner, M. J. (2002). Intimacy, Pleasure, Risk, and Safety: Discussion of Cheuvront's "High-Risk Sexual Behavior in the Treatment of HIV-Negative Patients."
Journal of Gay & Lesbian Psychotherapy, 6(3), 27–33.

Bourne, A., Ong, J., & Pakianathan, M. (2018). Sharing solutions for a reasoned and evidence-based response: chemsex / party and play among gay and bisexual men. *Sexual Health, 15(2)*, 99–101.
https://doi.org/10.1071/SH18023

Bowman, B., Psichogyiou, M., Papadopoulou, M., Sypsa, V., Khanna, A., Paraskevis, D., Chanos, S., Friedman, S. R., Hatzakis, A., & Schneider, J. (2021).
Sexual mixing and HIV transmission potential among Greek men who have sex with men: Results from SOPHOCLES.
AIDS and Behavior, 25(6), 1935–1945.
https://doi.org/10.1007/s10461-020-03123-6

Chemsex forum position paper. (n.d.). Ihp.Hiv. Retrieved November 21, 2022, from
https://ihp.hiv/chemsex-position-paper/

Daskalopoulou, M., Rodger, A., Phillips, A. N., Sherr, L., Speakman, A., Collins, S., Elford, J., Johnson, M. A., Gilson, R., Fisher, M., Wilkins, E., Anderson, J., McDonnell, J., Edwards, S., Perry, N., O'Connell, R., Lascar, M., Jones, M., Johnson, A. M., …

Lampe, F. C. (2014). Recreational drug use, polydrug use, and sexual behaviour in HIV-diagnosed men who have sex with men in the UK: results from the cross-sectional ASTRA study. *The Lancet. HIV, 1(1)*, e22-31.
https://doi.org/10.1016/S2352-3018(14)70001-3

Donnadieu-Rigole, H., Peyrière, H., Benyamina, A., & Karila, L. (2020). Complications related to sexualized drug use: What can we learn from literature?
Frontiers in Neuroscience, 14.
https://doi.org/10.3389/fnins.2020.548704

Drückler, S., van Rooijen, M. S., & de Vries, H. J. C. (2018). Chemsex Among Men Who Have Sex With Men: a Sexualized Drug Use Survey Among Clients of the Sexually Transmitted Infection Outpatient Clinic and Users of a Gay Dating App in Amsterdam, the Netherlands. *Sexually Transmitted Diseases, 45(5)*, 325–331.
https://doi.org/10.1097/olq.0000000000000753

Edmundson, C., Heinsbroek, E., Glass, R., Hope, V., Mohammed, H., White, M., & Desai, M. (2018). Sexualised drug use in the United Kingdom (UK): A review of the literature. *The International Journal on Drug Policy, 55*, 131–148.
https://doi.org/10.1016/j.drugpo.2018.02.002

Evans, K. (2019). The psychological roots of chemsex and how understanding the full picture can help us create meaningful support. *Drugs and Alcohol Today, 19(1)*, 36–41.
https://doi.org/10.1108/dat-10-2018-0062

Ford, J. V., Corona Vargas, E., Finotelli, I., Jr, Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *International Journal of Sexual Health: Official Journal of the World Association for Sexual Health, 31(3*), 217–230.
https://doi.org/10.1080/19317611.2019.1654587

Foucault, M. (2010). The Birth of Biopolitics: Lectures at the Coll ge de France, 1978--1979. *St Martin's Press.*

Foucault, M. (2016). Abnormal: Lectures at the college de France, 1974-1975. *Verso Books.*

Giorgetti, R., Tagliabracci, A., Schifano, F., Zaami, S., Marinelli, E., & Busardò, F. P. (2017). When "Chems" meet sex: A rising phenomenon called "ChemSex." *Current Neuropharmacology, 15(5)*, 762–770.
https://doi.org/10.2174/1570159X15666161117151148

Glynn, R. W., Byrne, N., O'Dea, S., Shanley, A., Codd, M., Keenan, E., Ward, M., Igoe, D., & Clarke, S. (2018). Chemsex, risk behaviours and sexually transmitted infections among men who have sex with men in Dublin, Ireland. *The International Journal on Drug Policy, 52*, 9–15.
https://doi.org/10.1016/j.drugpo.2017.10.008

Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters, 27(1)*, 1593787.
https://doi.org/10.1080/26410397.2019.1593787

Hammoud, M. A., Vaccher, S., Jin, F., Bourne, A., Haire, B., Maher, L., Lea, T., & Prestage, G. (2018). The new MTV generation: Using methamphetamine, TruvadaTM, and ViagraTM to enhance sex and stay safe. *The International Journal on Drug Policy, 55*, 197–204.
https://doi.org/10.1016/j.drugpo.2018.02.021

Hampel, B., Kusejko, K., Kouyos, R. D., Böni, J., Flepp, M., Stöckle, M., Conen, A., Béguelin, C., Künzler-Heule, P., Nicca, D., Schmidt, A. J., Nguyen, H., Delaloye, J., Rougemont, M., Bernasconi, E., Rauch, A., Günthard, H. F., Braun, D. L., Fehr, J., & Swiss HIV Cohort Study group. (2020). Chemsex drugs on the rise: a longitudinal analysis of the Swiss HIV Cohort Study from 2007 to 2017: Chemsex drugs on the rise in Switzerland. *HIV Medicine, 21(4)*, 228–239.
https://doi.org/10.1111/hiv.12821

Hegazi, A., Lee, M. J., Whittaker, W., Green, S., Simms, R., Cutts, R., Nagington, M., Nathan, B., & Pakianathan, M. R. (2017). Chemsex and the city: sexualised substance use in gay bisexual and other men who have sex with men attending sexual health clinics. *International Journal of STD & AIDS, 28(4)*, 362–366.
https://doi.org/10.1177/0956462416651229

Hibbert, M. P., Hillis, A., Brett, C. E., Porcellato, L. A., & Hope, V. D. (2021). A narrative systematic review of sexualised drug use and sexual health outcomes among LGBT people. *The International Journal on Drug Policy, 93(103187)*, 103187. https://doi.org/10.1016/j.drugpo.2021.103187

Íncera-Fernández, D., Gámez-Guadix, M., & Moreno-Guillén, S. (2021). Mental health symptoms associated with sexualized drug use (chemsex) among men who have sex with men: A systematic review. *International Journal of Environmental Research and Public Health, 18(24)*, 13299. https://doi.org/10.3390/ijerph182413299

Jaspal, R. (2022). Chemsex, identity and sexual health among gay and bisexual men. *International Journal of Environmental Research and Public Health, 19(19)*, 12124. https://doi.org/10.3390/ijerph191912124

Knoops, L., van Amsterdam, J., Albers, T., Brunt, T. M., & van den Brink, W. (2022). Slamsex in The Netherlands among men who have sex with men (MSM): use patterns, motives, and adverse effects. *Sexual Health.* https://doi.org/10.1071/sh22140

Lafortune, D., Blais, M., Miller, G., Dion, L., Lalonde, F., & Dargis, L. (2021). Psychological and interpersonal factors associated with sexualized drug use among men who have sex with men: A mixed-methods systematic review. *Archives of Sexual Behavior, 50(2)*, 427–460. https://doi.org/10.1007/s10508-020-01741-8

Lim, S. H., Akbar, M., Wickersham, J. A., Kamarulzaman, A., & Altice, F. L. (2018). The management of methamphetamine use in sexual settings among men who have sex with men in Malaysia. *The International Journal on Drug Policy, 55*, 256–262. https://doi.org/10.1016/j.drugpo.2018.02.019

Maxwell, S., Shahmanesh, M., & Gafos, M. (2019). Chemsex behaviours among men who have sex with men: A systematic review of the literature. *The International Journal on Drug Policy, 63, 74–89.* https://doi.org/10.1016/j.drugpo.2018.11.014

Melendez-Torres, G. J., Hickson, F., Reid, D., Weatherburn, P., & Bonell, C. (2017). Findings from within-subjects comparisons of drug use and sexual risk behaviour in men who have sex with men in England. *International Journal of STD & AIDS, 28(3)*, 250–258. https://doi.org/10.1177/0956462416642125

Ottaway, Z., Finnerty, F., Buckingham, T., & Richardson, D. (2017). Increasing rates of reported chemsex/sexualised recreational drug use in men who have sex with men attending for postexposure prophylaxis for sexual exposure. *Sexually Transmitted Infections, 93(1)*, 31. https://doi.org/10.1136/sextrans-2016-052877

Pakianathan, M., Whittaker, W., Lee, M. J., Avery, J., Green, S., Nathan, B., & Hegazi, A. (2018). Chemsex and new HIV diagnosis in gay, bisexual and other men who have sex with men attending sexual health clinics. *HIV Medicine, 19(7)*, 485–490. https://doi.org/10.1111/hiv.12629

Platteau, T., Pebody, R., Dunbar, N., Lebacq, T., & Collins, B. (2019). The problematic chemsex journey: a resource for prevention and harm reduction. *Drugs and Alcohol Today, 19(1)*, 49–54. https://doi.org/10.1108/dat-11-2018-0066

Poulios, A. (2020a). Εισαγωγή στο Chemsex: Από το φαινόμενο στο υποκείμενο [An Introduction to chemsex: From the phenomena to the subject]. In N. Papathanasiou & E. O. Christidi (Eds.), *Inclusion and Resilience (pp. 377–402)*. Gutenberg.

Poulios, A. (2020b). Σεξουαλικότητα και HIV: Gay και Κοινωνικώς Μεταδιδόμενα Νοσήματα [Sexuality and HIV: Gay and Socially Transmitted Diseases]. In N. Papathanasiou & E.-O. Christidi (Eds.), *Inclusion and Resilience (pp. 342–376)*.

Poulios, Antonios. (2022). Chemsex: Reintroducing sexuality in the pleasure and pain of the infans. *Studies in Gender and Sexuality, 23(3)*, 171–183. https://doi.org/10.1080/15240657.2022.2097472

Poulios, Antonios, Apostolidou, A., Triantafyllidou, S., Protopapas, K., Tapeinos, A., Papadopetrakis, G., Papadopoulou, M., Antoniadou, A., Psichogiou, M., & Canellopoulos, L. (2022). Sexualized drug use and chemsex: Their association with sexual health among men who have sex with men living in Greece. *International Journal of Sexual Health: Official Journal of the World Association for Sexual Health, 34(3), 450–461*. https://doi.org/10.1080/19317611.2022.2045417

Pufall, E. L., Kall, M., Shahmanesh, M., Nardone, A., Gilson, R., Delpech, V., Ward, H., & Positive Voices study group. (2018). Sexualized drug use ('chemsex') and high-risk sexual behaviours in HIV-positive men who have sex with men. *HIV Medicine, 19(4),* 261–270. https://doi.org/10.1111/hiv.12574

Rodger, A. J., Cambiano, V., Bruun, T., Vernazza, P., Collins, S., Degen, O., & Pechenot. (2019). Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. *The Lancet*, 393, 2428–2438.

Schmidt, A. J., Bourne, A., Weatherburn, P., Reid, D., Marcus, U., Hickson, F., & EMIS Network. (2016). Illicit drug use among gay and bisexual men in 44 cities: Findings from the European MSM Internet Survey (EMIS). *The International Journal on Drug Policy, 38*, 4–12. https://doi.org/10.1016/j.drugpo.2016.09.007

Schroeder, S. E., Bourne, A., Doyle, J. S., Hellard, M. E., Stoové, M., & Pedrana, A. (2022). Constructing a "target population": A critical analysis of public health discourse on substance use among gay and bisexual men, 2000-2020. *The International Journal on Drug Policy, 108(103808)*, 103808. https://doi.org/10.1016/j.drugpo.2022.103808

Smith, V., & Tasker, F. (2018). Gay men's chemsex survival stories. *Sexual Health, 15(2),* 116. https://doi.org/10.1071/sh17122

Strong, C., Huang, P., Li, C.-W., Ku, S. W.-W., Wu, H.-J., & Bourne, A. (2022). HIV, chemsex, and the need for harm-reduction interventions to support gay, bisexual, and other men who have sex with men. The Lancet. HIV, 9(10), e717–e725. https://doi.org/10.1016/s2352-3018(22)00124-2

Stuart, D. (2019). "Chemsex: origins of the word, a history of the phenomenon and a respect to the culture." *Drugs and Alcohol Today, 19(1)*, 3–10.

https://doi.org/10.1108/DAT-10-2018-0058

Tomkins, A., George, R., & Kliner, M. (2019). Sexualised drug taking among men who have sex with men: a systematic review. *Perspectives in Public Health, 139(1), 23–33.* https://doi.org/10.1177/1757913918778872

Torres, T. S., Bastos, L. S., Kamel, L., Bezerra, D. R. B., Fernandes, N. M., Moreira, R. I., Garner, A., Veloso, V. G., Grinsztejn, B., & De Boni, R. B. (2020). Do men who have sex with men who report alcohol and illicit drug use before/during sex (chemsex) present moderate/high risk for substance use disorders? *Drug and Alcohol Dependence, 209 (107908), 107908*.
https://doi.org/10.1016/j.drugalcdep.2020.107908

Weatherburn, P., Hickson, F., Reid, D., Torres-Rueda, S., & Bourne, A. (2017). Motivations and values associated with combining sex and illicit drugs ('chemsex') among gay men in South London: findings from a qualitative study. *Sexually Transmitted Infections, 93(3)*, 203–206.
https://doi.org/10.1136/sextrans-2016-052695

CHAPTER 2 – CHEMSEX: MORE THAN SEX AND DRUGS

Butler, J. (2009). Οι ψυχικές καταστάσεις της εξουσίας [The Psychic Life of Power]. *Plethron*.

Chemsex and harm reduction for gay men and other men who have sex with men. (2021, July 12). Harm Reduction International.
https://hri.global/publications/chemsex-and-harm-reduction-for-gay-men-and-other-men-who-have-sex-with-men/

Chemsex forum 2019 Paris. (n.d.). *Ihp.Hiv. Retrieved November 22*, 2022, from
https://ihp.hiv/csfparis/

Chemsex forum position paper. (n.d.). *Ihp.Hiv. Retrieved November 22*, 2022, from
https://ihp.hiv/chemsex-position-paper/

European Chemsex forum report. (n.d.). *IDPC. Retrieved November 22*, 2022, from
https://idpc.net/publications/2020/04/european-chemsex-forum-report

Foucault, M. (1984). The history of sexuality,vol.1: An introduction. *Penguin Books*.

Foucault, M. (2016). Abnormal: Lectures at the college de France, 1974-1975. *Verso Books*.

Ford, J. V., Corona Vargas, E., Finotelli, I., Jr, Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *International Journal of Sexual Health: Official Journal of the World Association for Sexual Health, 31(3)*, 217–230.
https://doi.org/10.1080/19317611.2019.1654587

Freud, S. (2018). Totem and taboo: Resemblances between the psychic lives of savages and neurotics. *Franklin Classics*.

Freud, S. (2021). Civilization and its discontents (S. Moyn, Ed.; J. Strachey, Trans.). *W. W. Norton & Company*.

Gender, sexuality, sex and drugs. (2022, October 15). *Harm Reduction International*.
https://hri.global/topics/intersectional-movements/gender-sexuality-drugs/

Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters, 27(1), 1593787.*
https://doi.org/10.1080/26410397.2019.1593787

Home. (2022, October 8). *Harm Reduction International*.
https://hri.global/

Lacan, J. (2014). The Mirror Stage as Formative of the Function of the I as Revealed in Psychoanalytic Experience1. *In Reading French Psychoanalysis (pp. 97–104)*.

Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: a practice-friendly review of research. *Journal of Clinical Psychology*.
https://doi.org/10.1002/jclp.20669

McDougall, J. (2002). Addiction: a psychosomatic solution. *International Congress Series. Excerpta Medica, 1241*, 345–351.
https://doi.org/10.1016/s0531-5131(02)00771-9

Olievenstein, C. (1982). Η ζωή του τοξικομανή [Drugs or Life]. Pallada.

Olivienstein, C. (1987). Το μη-λεχθέν των συναισθημάτων [The Unspoken of Emotions]. Kedros.

Poulios, A. (2022). Chemsex: Reintroducing sexuality in the pleasure and pain of the infans. *Studies in Gender and Sexuality, 23(3*), 171–183.
https://doi.org/10.1080/15240657.2022.2097472

Poulios, A. (2020). Εισαγωγή στο Chemsex: Από το φαινόμενο στο υποκείμενο [An Introduction to chemsex: From the phenomena to the subject]. In C. E. O. Papathanasiou N (Ed.), *Inclusion and Resilience. (pp. 377–402)*. Gutenberg.

Ramprashad, A., Burnett, G. M., & Welsh, C. (2022). Harm reduction. The Psychiatric Clinics of North America, 45(3), 529–546.
https://doi.org/10.1016/j.psc.2022.04.005

Rigoni, R., Tammi, T., Van Der Gouwe, D., & Moura, J. (n.d.). Civil Society Monitoring of Harm Reduction in Europe, 2021. *Data Report. Amsterdam, Correlation - European Harm Reduction Network.*

Sansone, A., Limoncin, E., Colonnello, E., Mollaioli, D., Ciocca, G., Corona, G., & Jannini, E. A. (2022). Harm reduction in sexual medicine. *Sexual Medicine Reviews, 10(1), 3–22.*
https://doi.org/10.1016/j.sxmr.2021.01.005

Schroeder, S. E., Bourne, A., Doyle, J. S., Hellard, M. E., Stoové, M., & Pedrana, A. (2022). Constructing a "target population": A critical analysis of public health discourse on substance use among gay and bisexual men, 2000-2020. *The International Journal on Drug Policy, 108(103808)*, 103808.
https://doi.org/10.1016/j.drugpo.2022.103808

Webinar Series. (n.d.). *EuroNPUD*.
https://www.euronpud.net/webinar-series

What is harm reduction? (2022, October 8). *Harm Reduction International*.
https://hri.global/what-is-harm-reduction/

Zaltzman, N. (1979). Η αναρχική ενόρμηση [The Anarchic Drive]. *Estia*.

CHAPTER 3 – SUBSTANCES OF SEX; CHEMS, EFFECTS AND HARM REDUCTION

20142 GHB. (n.d.). *CAMH. Retrieved November 28, 2022*, from https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/ghb

Alisauskiene, R., Løberg, E.-M., Gjestad, R., Kroken, R. A., Jørgensen, H. A., & Johnsen, E. (2019). The influence of substance use on the effectiveness of antipsychotic medication: a prospective, pragmatic study. *Nord. J. Psychiatry, 73(4–5)*, 281–287.

Allerton, M., & Blake, W. (2008). The ``party drug" crystal methamphetamine: *Risk factor for the acquisition of HIV. Perm. J., 12(1)*, 56–58.

Anderson, A. L., Li, S.-H., Biswas, K., McSherry, F., Holmes, T., Iturriaga, E., Kahn, R., Chiang, N., Beresford, T., Campbell, J., Haning, W., Mawhinney, J., McCann, M., Rawson, R., Stock, C., Weis, D., Yu, E., & Elkashef, A. M. (2012). Modafinil for the treatment of methamphetamine dependence. *Drug Alcohol Depend., 120(1–3)*, 135–141.

Anglin, M. D., Burke, C., Perrochet, B., Stamper, E., & Dawud-Noursi, S. (2000). History of the methamphetamine problem. *J. Psychoactive Drugs, 32(2)*, 137–141.

Aniline, O., & Pitts, F. N., Jr. (1982). Phencyclidine (PCP): a review and perspectives. *Crit. Rev. Toxicol., 10(2)*, 145–177.

Brunt, T. M., Poortman, A., Niesink, R. J. M., & van den Brink, W. (2011). *Instability of the ecstasy market and a new kid on the block: mephedrone. J. Psychopharmacol., 25(11)*, 1543–1547.

Busardò, F. P., Kyriakou, C., Napoletano, S., Marinelli, E., & Zaami, S. (2015). *Mephedrone related fatalities: a review. Eur. Rev. Med. Pharmacol. Sci., 19(19)*, 3777–3790.

Busardò, Francesco P., & Jones, A. W. (2015). GHB pharmacology and toxicology: acute intoxication, concentrations in blood and urine in forensic cases and treatment of the withdrawal syndrome. *Curr. Neuropharmacol., 13(1)*, 47–70.

Buxton, J. A., & Dove, N. A. (2008). *The burden and management of crystal meth use. CMAJ, 178(12)*, 1537–1539.

Casey, M. K., & Casey, J. N. (2019). *Helping my friend. Independently Published*.

ChemFriendly. (n.d.). Chemfriendly.No. *Retrieved November 28*, 2022, from https://chemfriendly.no/

Chemsex booklet. (n.d.). Positivevoice.Gr. *Retrieved November 28*, 2022, from https://positivevoice.gr/wp-content/uploads/2020/10/chemsex-booklet_web_new.pdf

Chemsex drugs: how to keep yourself safe. (n.d.). Changegrowlive.org. *Retrieved November 28*, 2022, from https://www.changegrowlive.org/chemsex-mephedrone-meth-GHB-GBL

Chemsex first aid. (n.d.). David Stuart. *Retrieved November 28*, 2022, from https://www.davidstuart.org/chemsex-first-aid

Clark, R. (2014, February). *Ketamine. DanceSafe.*
https://dancesafe.org/ketamine/

Cocaine. (n.d.-a). Drugsand.Me. *Retrieved November 28*, 2022, from
https://www.drugsand.me/en/drugs/cocaine/

Cocaine. (n.d.-b). S-x.Scot. *Retrieved November 28*, 2022, from
https://s-x.scot/sex-relationships/chemsex/cocaine/

Cocaine. (2021, June). Party and Play.
https://partyandplay.info/for-guys/drug-info/cocaine/

Cocaine - advice for staying safe and cutting down. (n.d.). Changegrowlive.org. *Retrieved November 28*, 2022, from
https://www.changegrowlive.org/advice-info/alcohol-drugs/cocaine-advice-harm-reduction

Cocaine -- Friday/Monday. (2016, December). *Friday / Monday.*
https://www.fridaymonday.org.uk/drug-types/cocaine/

Coffin, P. O., Santos, G.-M., Hern, J., Vittinghoff, E., Santos, D., Matheson, T., Colfax, G., & Batki, S. L. (2018). Extended-release naltrexone for methamphetamine dependence among men who have sex with men: a randomized placebo-controlled trial. *Addiction, 113(2)*, 268–278.

Colfax, G. N., Santos, G.-M., Das, M., Santos, D. M., Matheson, T., Gasper, J., Shoptaw, S., & Vittinghoff, E. (2011). Mirtazapine to reduce methamphetamine use: a randomized controlled trial: A randomized controlled trial. *Arch. Gen. Psychiatry, 68(11)*, 1168–1175.

Corriger, A., & Pickering, G. (2019). Ketamine and depression: a narrative review. *Drug Des. Devel. Ther., 13*, 3051–3067.

Crystal Meth. (n.d.). S-x.Scot. Retrieved November 28, 2022, from
https://s-x.scot/sex-relationships/chemsex/crystal-meth/

Crystal meth. (2020, October). Party and Play.
https://partyandplay.info/for-guys/drug-info/crystal-meth/

Crystal meth / Tina: Chemsex support. (2020, August). 56 Dean Street.
https://www.dean.st/chemsex/chems-crystal-meth/

Delic, M. (2019). Inpatient management of GHB/GBL withdrawal. *Psychiatr. Danub., 31(Suppl 3)*, 354–356.

Dobkin, C., & Nicosia, N. (2009). The war on drugs: Methamphetamine, public health, and crime. *Am. Econ. Rev., 99(1)*, 324–349.

Donnadieu-Rigole, H., Peyrière, H., Benyamina, A., & Karila, L. (2020). Complications related to sexualized drug use: What can we learn from literature? *Front. Neurosci., 14, 548704*.

Dore, G., & Sweeting, M. (2006). Drug-induced psychosis associated with crystalline methamphetamine. *Australas. Psychiatry, 14(1)*, 86–89.

Drake, L. R., & Scott, P. J. H. (2018). DARK classics in chemical neuroscience: Cocaine. *ACS Chem. Neurosci., 9(10)*, 2358–2372.

Drug and Alcohol Information and Support in Ireland - Drugs.Ie. (n.d.). Drugs.Ie. Retrieved November 28, 2022, from http://www.drugs.ie

Dybdal-Hargreaves, N. F., Holder, N. D., Ottoson, P. E., Sweeney, M. D., & Williams, T. (2013). Mephedrone: Public health risk, mechanisms of action, and behavioral effects. *Eur. J. Pharmacol., 714(1–3)*, 32–40.

Erowid. (n.d.). *Erowid 4-Methylmethcathinone Vault : Effects.* Erowid.org. Retrieved November 28, 2022, from https://www.erowid.org/chemicals/4_methylmethcathinone/4_methylmethcathinone_effects.shtml

EROWID. (2015). Methamphetamine dose. In *EROWID*.

Friday / Monday. (n.d.). Friday/ Monday. Retrieved November 28, 2022, from https://www.fridaymonday.org.uk

G (ghb/gbl). (2018, August). London Friend. https://londonfriend.org.uk/ghb-gbl

Gay Men's Sexual Health Alliance. (2022). *Crystal Meth*. Party and Play. https://partyandplay.info/for-guys/drug-info/crystal-meth/

GHB. (n.d.). Gov.au. Retrieved November 28, 2022, from https://www.betterhealth.vic.gov.au/health/healthyliving/GHB

Giorgetti, R., Tagliabracci, A., Schifano, F., Zaami, S., Marinelli, E., & Busardò, F. P. (2017). When ``Chems" meet sex: A rising phenomenon called ``ChemSex". *Curr. Neuropharmacol., 15(5)*, 762–770.

GMFA - the sexual wellbeing project. (n.d.). LGBT HERO - the National Health and Wellbeing Charity. Retrieved November 28, 2022, from http://www.gmfa.org.uk

Gmfa.org. (n.d.). Gmfa.org. Retrieved November 28, 2022, from http://www.gmfa.org

Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. (n.d.). Neptune-clinical-guidance. co.uk. Retrieved November 28, 2022, from http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf

Harm reduction: Ketamine. (n.d.). Oxfordsu.org. Retrieved November 28, 2022, from https://www.oxfordsu.org/support/resourcehub/harmreductionketamine

Herie, M., Godden, T., Shenfeld, J., & Kelly, C. (n.d.). *Addiction An information guide.* Camh.Ca. Retrieved November 28, 2022, from https://www.camh.ca/-/media/files/guides-and-publications/addiction-guide-en.pdf

History of mephedrone. (2015, September). TD Consultancy; TD Consultancy - Drug Training & Consultancy. https://tonydagostino.co.uk/history-of-mephedrone/

Kampman, K. M. (2019). The treatment of cocaine use disorder. *Sci. Adv., 5(10)*, eaax1532.

Ketamine. (n.d.). S-x.Scot. Retrieved November 28, 2022, from https://s-x.scot/sex-relationships/chemsex/ketamine

Ketamine. (2021, June). Party and Play. https://partyandplay.info/for-guys/drug-info/ketamine/

Ketamine: Mild dissociative state: case report. (2017). *React. Wkly., 1638*(1), 131–131.

Ketamine: Severe urinary tract dysfunction: 4 case reports. (2013). *React. Wkly., 1474*(1), 26–26.

Kish, S. J. (2008). Pharmacologic mechanisms of crystal meth. *CMAJ, 178*(13), 1679–1682.

Kudlacek, O., Hofmaier, T., Luf, A., Mayer, F. P., Stockner, T., Nagy, C., Holy, M., Freissmuth, M., Schmid, R., & Sitte, H. H. (2017). Cocaine adulteration. *J. Chem. Neuroanat.*, 83–84, 75–81.

Laborit, H. (1964). Sodium 4-hydroxybutyrate. *Int. J. Neuropharmacol., 3*(4), 433–451.

Lappin, J. M., Roxburgh, A., Kaye, S., Chalmers, J., Sara, G., Dobbins, T., Burns, L., & Farrell, M. (2016). Increased prevalence of self-reported psychotic illness predicted by crystal methamphetamine use: Evidence from a high-risk population. *Int. J. Drug Policy, 38*, 16–20.

Measham, F., Moore, K., & Newcombe, R. (2010). Tweaking, bombing, dabbing and stockpiling: the emergence of mephedrone and the perversity of prohibition. *Drugs Alcohol Today, 10*(1), 14–21.

Melega, W. P., Cho, A. K., Harvey, D., & Laćan, G. (2007). Methamphetamine blood concentrations in human abusers: application to pharmacokinetic modeling. *Synapse, 61*(4), 216–220.

Mephedrone. (2021, March). Bristol Drugs Project. https://www.bdp.org.uk/get-information/drugs-information/mephedrone/

Meredith, C. W., Jaffe, C., Ang-Lee, K., & Saxon, A. J. (2005). Implications of chronic methamphetamine use: a literature review. *Harv. Rev. Psychiatry, 13*(3), 141–154.

Mihaljevic, S., Department of Anaesthesiology, Reanimatology and Intensive Care Medicine, University Hospital Centre Zagreb, Zagreb, Croatia, Pavlovic, M., Reine, K., Cacic, M., Department of Psychiatry, General Hospital Bjelovar, Bjelovar, Croatia, Department of Anesthesiology and Intensive Care Medicine, Clinic for Obstetrics and Gynecology, University Clinical Hospital Centre Zagreb, Zagreb, Croatia, & Department of Cardiology, St. Antonius Hospital Kleve, Kleve, Germany. (2020). Therapeutic mechanisms of ketamine. *Psychiatr. Danub., 32*(3–4), 325–333.

Morgan, C. J. A., Curran, H. V., & Independent Scientific Committee on Drugs. (2012). Ketamine use: a review: Ketamine use: a review. *Addiction, 107*(1), 27–38.

Morgan, C. J. A., Perry, E. B., Cho, H.-S., Krystal, J. H., & D'Souza, D. C. (2006). Greater vulnerability to the amnestic effects of ketamine in males. *Psychopharmacology (Berl.), 187*(4), 405–414.

Muetzelfeldt, L., Kamboj, S. K., Rees, H., Taylor, J., Morgan, C. J. A., & Curran, H. V. (2008). Journey through the K-hole: phenomenological aspects of ketamine use. *Drug Alcohol Depend., 95*(3), 219–229.

Nassar, P., & Ouanounou, A. (2020). Cocaine and methamphetamine: Pharmacology and dental implications. *Can. J. Dent. Hyg., 54*(2), 75–82.

National Institute on Drug Abuse. (2021, April). *Cocaine DrugFacts*. National Institute on Drug Abuse. https://nida.nih.gov/publications/drugfacts/cocaine

Nowacka, A., & Borczyk, M. (2019). Ketamine applications beyond anesthesia -- A literature review. *Eur. J. Pharmacol., 860*(172547), 172547.

Nuh, O. (n.d.). *Interactions between HIV treatment and recreational drugs. Aidsmap.com*. Retrieved November 28, 2022, from https://www.aidsmap.com/about-hiv/interactions-between-hiv-treatment-and-recreational-drugs

Panenka, W. J., Procyshyn, R. M., Lecomte, T., MacEwan, G. W., Flynn, S. W., Honer, W. G., & Barr, A. M. (2013). Methamphetamine use: a comprehensive review of molecular, preclinical and clinical findings. *Drug Alcohol Depend., 129*(3), 167–179.

Papaseit, E., Moltó, J., Muga, R., Torrens, M., de la Torre, R., & Farré, M. (2016). Clinical pharmacology of the synthetic cathinone mephedrone. In *Neuropharmacology of New Psychoactive Substances (NPS)* (pp. 313–331). Springer International Publishing.

Papaseit, E., Pérez-Mañá, C., Mateus, J.-A., Pujadas, M., Fonseca, F., Torrens, M., Olesti, E., de la Torre, R., & Farré, M. (2016). Human pharmacology of mephedrone in comparison with MDMA. *Neuropsychopharmacology, 41*(11), 2704–2713.

Petit, A., Karila, L., Sananes, M., & Lejoyeux, M. (2013). La méphédrone : une nouvelle drogue de synthèse. *Presse Med., 42*(10), 1310–1316.

Raposo Pereira, F., Zhutovsky, P., Mcmaster, M. T. B., Polderman, N., Vries, Y. D. A. T., Brink, W., & Wingen, G. A. (2019). Recreational use of GHB is associated with alterations of resting state functional connectivity of the central executive and default mode networks. *Hum. Brain Mapp., 40*(8), 2413–2421.

Razavi, Y., Keyhanfar, F., Shabani, R., Haghparast, A., & Mehdizadeh, M. (2021). Therapeutic effects of cannabidiol on methamphetamine abuse: A review of preclinical study. *Iran. J. Pharm. Res., 20*(4), 152–164.

Richards, J. R., & Laurin, E. G. (2022). Methamphetamine Toxicity. In *StatPearls [Internet]*. StatPearls Publishing.

Riezzo, I., Fiore, C., De Carlo, D., Pascale, N., Neri, M., Turillazzi, E., & Fineschi, V. (2012). Side effects of cocaine abuse: Multiorgan toxicity and pathological consequences. *Curr. Med. Chem., 19*(33), 5624–5646.

Scotton, W. J., Hill, L. J., Williams, A. C., & Barnes, N. M. (2019). Serotonin syndrome: Pathophysiology, clinical features, management, and potential future directions. *Int. J. Tryptophan Res., 12*, 1178646919873925.

Shoptaw, S., Heinzerling, K. G., Rotheram-Fuller, E., Steward, T., Wang, J., Swanson, A.-N., De La Garza, R., Newton, T., & Ling, W. (2008). Randomized, placebo-controlled trial of bupropion for the treatment of methamphetamine dependence. *Drug Alcohol Depend., 96*(3), 222–232.

Soria, M. L. (2021). Aspectos toxicológicos del chemsex. *Rev. esp. med. leg., 47*(2), 74–80.

Spillane, J. F. (2004). Debating the Controlled Substances Act. *Drug Alcohol Depend., 76*(1), 17–29.

SPRAVATO. (n.d.). Gov.au. Retrieved November 28, 2022, from https://www.tga.gov.au/sites/default/files/auspar-esketamine-hydrochloride-210507-pi.pdf

Super User. (n.d.). *MEPHEDRONE INFORMATION FOR HUMAN CONSUMPTION - free*. Substancemisuseresources.co.uk. Retrieved November 28, 2022, from https://www.substancemisuseresources.co.uk/harm-reduction-information/mephedrone-information-for-human-consumption-free

Tamura, M. (1989). Japan: stimulant epidemics past and present. Bull. Narc., 41(1–2), 83–93.

The alcohol and drug foundation. (n.d.). Org.au. Retrieved November 28, 2022, from https://adf.org.au/]

The alcohol and Drug Foundation - alcohol and Drug Foundation. (n.d.). Org.au. Retrieved November 28, 2022, from https://adf.org.au

Tina and Slamming. (2015). Idpc.net. http://fileserver.idpc.net/library/Tina_and_Slamming_English_summary.pdf

Urbina, A., & Jones, K. (2004). Crystal methamphetamine, its analogues, and HIV infection: medical and psychiatric aspects of a new epidemic. *Clin. Infect. Dis., 38*(6), 890–894.

Welcome to 56 Dean Street - STI screening, PrEP and HIV services. (2020, May). 56 Dean Street. http://dean.st/

Winstock, A., Mitcheson, L., Ramsey, J., Davies, S., Puchnarewicz, M., & Marsden, J. (2011). Mephedrone: use, subjective effects and health risks: Mephedrone and health risks. *Addiction, 106*(11), 1991–1996.

Winstock, A. R., Mitcheson, L. R., Deluca, P., Davey, Z., Corazza, O., & Schifano, F. (2011). Mephedrone, new kid for the chop?: Mephedrone and legal highs. *Addiction, 106*(1), 154–161.

Wood, D. M., & Dargan, P. I. (2013). *Mephedrone. In Novel Psychoactive Substances.* Elsevier.

Yu, S., Zhu, L., Shen, Q., Bai, X., & Di, X. (2015). Recent advances in methamphetamine neurotoxicity mechanisms and its molecular pathophysiology. *Behav. Neurol., 2015*, 103969.

Zanos, P., Moaddel, R., Morris, P. J., Riggs, L. M., Highland, J. N., Georgiou, P., Pereira, E. F. R., Albuquerque, E. X., Thomas, C. J., Zarate, C. A., Jr, & Gould, T. D. (2018). Ketamine and ketamine metabolite pharmacology: Insights into therapeutic mechanisms. *Pharmacol. Rev., 70*(3), 621–660.

Casey, M. K., & Casey, J. N. (2019). *Helping my friend*. Independently Published.

ChemFriendly. (n.d.). Chemfriendly.No. Retrieved November 28, 2022, from https://chemfriendly.no/

Chemsex (aka "party and play. (n.d.). Org.au. Retrieved December 10, 2022, from https://cracksintheice.org.au/document/library/chemsex-and-crystal-methamphetamine-factsheet.pdf

Chemsex and harm reduction for gay men and other men who have sex with men. (2022, July). Aidsactioneurope.org. https://www.aidsactioneurope.org/sites/default/files/HRI_Briefing_Chemsex_July_2021_Final.pdf

Chemsex booklet. (n.d.). Positivevoice.Gr. Retrieved November 28, 2022, from https://positivevoice.gr/wp-content/uploads/2020/10/chemsex-booklet_web_new.pdf

Chemsex drugs: how to keep yourself safe. (n.d.). Changegrowlive.org. Retrieved November 28, 2022, from https://www.changegrowlive.org/chemsex-mephedrone-meth-GHB-GBL

Chemsex tips. (2020, August 12). 56 Dean Street. https://www.dean.st/chemsex/chemsex-tips/

Cocaine. (n.d.-a). Drugsand.Me. Retrieved November 28, 2022, from https://www.drugsand.me/en/drugs/cocaine/

Cocaine. (n.d.-b). S-x.Scot. Retrieved November 28, 2022, from https://s-x.scot/sex-relationships/chemsex/cocaine/

Cocaine. (2021, June 28). Party and Play. https://partyandplay.info/for-guys/drug-info/cocaine/

Cocaine - advice for staying safe and cutting down. (n.d.). Changegrowlive.org. Retrieved November 28, 2022, from https://www.changegrowlive.org/advice-info/alcohol-drugs/cocaine-advice-harm-reduction

Cocaine – Friday/Monday. (2016, December 9). Friday/Monday. https://www.fridaymonday.org.uk/drug-types/cocaine/

Crystal Meth. (n.d.). S-x.Scot. Retrieved November 28, 2022, from https://s-x.scot/sex-relationships/chemsex/crystal-meth/

Crystal meth. (2020, October 22). Party and Play. https://partyandplay.info/for-guys/drug-info/crystal-meth/

Crystal meth / Tina: Chemsex support. (2020, August 12). 56 Dean Street. https://www.dean.st/chemsex/chems-crystal-meth/

Drake, L. R., & Scott, P. J. H. (2018). DARK classics in chemical neuroscience: Cocaine. *ACS Chemical Neuroscience, 9*(10), 2358–2372. https://doi.org/10.1021/acschemneuro.8b00117

Drug and Alcohol Information and Support in Ireland - Drugs.Ie. (n.d.). Drugs.Ie. Retrieved November 28, 2022, from http://www.drugs.ie

Ford, J. V., Corona Vargas, E., Finotelli, I., Jr, Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *International Journal of Sexual Health: Official Journal of the World Association for Sexual Health, 31*(3), 217–230. https://doi.org/10.1080/19317611.2019.1654587

Friday/Monday. (n.d.). Friday/Monday. Retrieved November 28, 2022, from https://www.fridaymonday.org.uk

G (ghb/gbl). (2018, August 31). London Friend. https://londonfriend.org.uk/ghb-gbl

General tips - harm reduction. (n.d.). Let’s Talk about It. Retrieved December 10, 2022, from https://www.letstalkaboutit.nhs.uk/other-services/chemsex-support/general-tips-harm-reduction/

GMFA - the sexual wellbeing project. (n.d.). LGBT HERO - the National Health and Wellbeing Charity. Retrieved November 28, 2022, from http://www.gmfa.org.uk

Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters, 27*(1), 1593787. https://doi.org/10.1080/26410397.2019.1593787

Harm reduction: Ketamine. (n.d.). Oxfordsu.org. Retrieved November 28, 2022, from https://www.oxfordsu.org/support/resourcehub/harmreductionketamine

Herrijgers, C., Poels, K., Vandebosch, H., Platteau, T., van Lankveld, J., & Florence, E. (2020). Harm reduction practices and needs in a Belgian chemsex context: Findings from a qualitative study. *International Journal of Environmental Research and Public Health, 17*(23), 9081. https://doi.org/10.3390/ijerph17239081

Kampman, K. M. (2019). The treatment of cocaine use disorder. *Science Advances, 5*(10), eaax1532. https://doi.org/10.1126/sciadv.aax1532

Ketamine. (n.d.). S-x.Scot. Retrieved November 28, 2022, from https://s-x.scot/sex-relationships/chemsex/ketamine

Ketamine. (2021, June 29). Party and Play. https://partyandplay.info/for-guys/drug-info/ketamine/

Ketamine: Mild dissociative state: case report. (2017). Reactions Weekly, 1638(1), 131–131. https://doi.org/10.1007/s40278-017-26217-6

Ketamine: Severe urinary tract dysfunction: 4 case reports. (2013). Reactions Weekly, 1474(1), 26–26. https://doi.org/10.1007/s40278-013-6625-6

Kudlacek, O., Hofmaier, T., Luf, A., Mayer, F. P., Stockner, T., Nagy, C., Holy, M., Freissmuth, M., Schmid, R., & Sitte, H. H. (2017). Cocaine adulteration. *Journal of Chemical Neuroanatomy, 83–84*, 75–81. https://doi.org/10.1016/j.jchemneu.2017.06.001

Ma, R., & Perera, S. (2016). Safer “chemsex”: GPs’ role in harm reduction for emerging forms of recreational drug use. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 66*(642), 4–5. https://doi.org/10.3399/bjgp16X683029

Mephedrone. (2021, March 24). Bristol Drugs Project. https://www.bdp.org.uk/get-information/drugs-information/mephedrone/

Morgan, C. J. A., Curran, H. V., & Independent Scientific Committee on Drugs. (2012). Ketamine use: a review: Ketamine use: a review. *Addiction (Abingdon, England), 107*(1), 27–38. https://doi.org/10.1111/j.1360-0443.2011.03576.x

Nassar, P., & Ouanounou, A. (2020). Cocaine and methamphetamine: Pharmacology and dental implications. *Canadian Journal of Dental Hygiene, 54*(2), 75–82.

National Institute on Drug Abuse. (2021, April 8). *Cocaine DrugFacts.* National Institute on Drug Abuse. https://nida.nih.gov/publications/drugfacts/cocaine

Riezzo, I., Fiore, C., De Carlo, D., Pascale, N., Neri, M., Turillazzi, E., & Fineschi, V. (2012). Side effects of cocaine abuse: Multiorgan toxicity and pathological consequences. *Current Medicinal Chemistry, 19*(33), 5624–5646. https://doi.org/10.2174/092986712803988893

Starting Out | General Recommendations. (n.d.). Chemsexharmreduction.org. Retrieved December 10, 2022, from https://www.chemsexharmreduction.org/for-providers/harm-reduction/general-recommendations

Super User. (n.d.). MEPHEDRONE INFORMATION FOR HUMAN CONSUMPTION - free. Substancemisuseresources.co.uk. Retrieved November 28, 2022, from https://www.substancemisuseresources.co.uk/harm-reduction-information/mephedrone-information-for-human-consumption-free

The alcohol and drug foundation. (n.d.). Org.au. Retrieved November 28, 2022, from https://adf.org.au/]

The alcohol and Drug Foundation - alcohol and Drug Foundation. (n.d.). Org.au. Retrieved November 28, 2022, from https://adf.org.au

Tina and Slamming. (2015). Idpc.net. http://fileserver.idpc.net/library/Tina_and_Slamming_English_summary.pdf

Tools & tips. (2020, August 12). Party and Play. https://partyandplay.info/for-guys/tools-tips/

Welcome to 56 Dean Street - STI screening, PrEP and HIV services. (2020, May 23). 56 Dean Street. http://dean.st/

CHAPTER 5 – BUILDING CHEMS-FRIENDLY SERVICES

ACON. (n.d.). Https://www.acon.org.au/. Retrieved December 19, 2022, from http://www.acon.org.au

Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *The American Journal of Occupational Therapy: Official Publication of the American Occupational Therapy Association, 74*(4), 7404347010p1-7404347010p7. https://doi.org/10.5014/ajot.2020.038067

Amsterdam. (n.d.). English. GGD Amsterdam. Retrieved December 19, 2022, from https://www.ggd.amsterdam.nl/english/

Bakker, I., & Knoops, L. (2018). Towards a continuum of care concerning chemsex issues. *Sexual Health, 15*(2), 173. https://doi.org/10.1071/sh17139

Bardsley, M., Steventon, A., Smith, J., & Dixon, J. (2013). *Evaluating integrated and community-based care.* Nuffield Trust.

Barmania, S. (2022). HERO—providing support for those engaged in chemsex. *The Lancet. HIV, 9*(10), e677. https://doi.org/10.1016/s2352-3018(22)00247-8

Bourne, A., Ong, J., & Pakianathan, M. (2018). Sharing solutions for a reasoned and evidence-based response: chemsex/party and play among gay and bisexual men. *Sexual Health, 15*(2), 99. https://doi.org/10.1071/sh18023

Brown, E., Brown, C., Johnson, O., Inman, W., Briggs, R., Burrell, W., Theriot, R., Williams, E., & Heaston, A. (2019). Using community-based participatory research to assess the needs of HIV-related services for infected individuals in rural communities. *Journal of Community Engagement and Scholarship, 12*(1). https://doi.org/10.54656/jnio1504

Carrico, A. W., Flentje, A., Gruber, V. A., Woods, W. J., Discepola, M. V., Dilworth, S. E., Neilands, T. B., Jain, J., & Siever, M. D. (2014). Community-based harm reduction substance abuse treatment with methamphetamine-using men who have sex with men. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 91*(3), 555–567. https://doi.org/10.1007/s11524-014-9870-y

Chem-Safe. (2016, December 19). Chem-Safe; Energy Control. https://www.chem-safe.org/

ChemSex. (2022, January 17). ChemSex; ASA associazione solidarietà AIDS. http://www.chemsex.it

Chemsex.info. (2017, May 17). chemsex.info. https://chemsex.info/

Chow, L., & St. John, M. S. (2021). “A difficulty in the path of psychoanalysis”: The community psychoanalysis consortium and the community consultants. *Psychoanalytic Dialogues, 31*(4), 439–449. https://doi.org/10.1080/10481885.2021.1926792

Christidi, E. O., & Papathanasiou, N. (2020). Βασικές κατευθυντήριες οδηγίες στη συμβουλευτική και την ψυχοθεραπεία με ΛΟΑΤΚΙ+ άτομα [Basic guidelines in counseling and psychotherapy with LGBTI+ people]. In Nancy Papathanasiou & E. O. Christidi (Eds.), *Inclusion and Resilience* (pp. 86–140). Gutenberg.

Crisp, C., & McCave, E. L. (2007). Gay affirmative practice: A model for social work practice with gay, lesbian, and bisexual youth. *Child & Adolescent Social Work Journal: C & A, 24*(4), 403–421.
https://doi.org/10.1007/s10560-007-0091-z

Davies, D. (1996). Pink therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients (D. Davies & C. Neal, Eds.). *Open University Press.*

Dávila, P. F. (2022). “Nada sobre nosotr@s, sin nosotr@s”: la Investigación Basada en la Comunidad como enfoque necesario en los estudios con poblaciones clave. *Revista Multidisciplinar Del Sida, 10*(27), 45–56.

Drahota, A., Meza, R. D., Brikho, B., Naaf, M., Estabillo, J. A., Gomez, E. D., Vejnoska, S. F., Dufek, S., Stahmer, A. C., & Aarons, G. A. (2016). Community-academic partnerships: A systematic review of the state of the literature and recommendations for future research: Systematic review of community-academic partnerships. *The Milbank Quarterly, 94*(1), 163–214.
https://doi.org/10.1111/1468-0009.12184

El Arifeen, S., Christou, A., Reichenbach, L., Osman, F. A., Azad, K., Islam, K. S., Ahmed, F., Perry, H. B., & Peters, D. H. (2013). Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh. *Lancet, 382*(9909), 2012–2026.
https://doi.org/10.1016/s0140-6736(13)62149-2

Everly, G. S., Barnett, D. J., & Links, J. M. (2012). The Johns Hopkins model of psychological first aid (RAPID-PFA): Curriculum development and content validation. *International Journal of Emergency Mental Health.*

Everly, George S., Jr, Lee McCabe, O., Semon, N. L., Thompson, C. B., & Links, J. M. (2014). The development of a model of psychological first aid for non-mental health trained public health personnel: the Johns Hopkins RAPID-PFA: The johns Hopkins RAPID-PFA. *Journal of Public Health Management and Practice: JPHMP, 20 Suppl 5*(Supplement 5), S24-9.
https://doi.org/10.1097/PHH.0000000000000065

Fawcett, D. M. (2015). Lust, men, and meth: *A gay man’s guide to sex and recovery*. S FL Center for Counseling and Therapy.

Ford, J. V., Corona Vargas, E., Finotelli, I., Jr, Fortenberry, J. D., Kismödi, E., Philpott, A., Rubio-Aurioles, E., & Coleman, E. (2019). Why pleasure matters: Its global relevance for sexual health, sexual rights and wellbeing. *International Journal of Sexual Health: Official Journal of the World Association for Sexual Health, 31*(3), 217–230.
https://doi.org/10.1080/19317611.2019.1654587

Friday / Monday. (n.d.). Friday / Monday. Retrieved December 19, 2022, from
http://www.fridaymonday.org.uk

Garcia, D. (1990). (Sin título). *Chasqui, 19*(1), 135.
https://doi.org/10.2307/29740258

González, F. J., & Peltz, R. (2021). Community psychoanalysis: Collaborative practice as intervention. *Psychoanalytic Dialogues, 31*(4), 409–427. https://doi.org/10.1080/10481885.2021.1926788

Gruskin, S., Yadav, V., Castellanos-Usigli, A., Khizanishvili, G., & Kismödi, E. (2019). Sexual health, sexual rights and sexual pleasure: meaningfully engaging the perfect triangle. *Sexual and Reproductive Health Matters, 27*(1), 1593787. https://doi.org/10.1080/26410397.2019.1593787

Hettema, J., Wagner, C. C., Ingersoll, K. S., & Russo, J. M. (2014). Brief interventions and motivational interviewing (K. J. Sher, Ed.). Oxford University Press.

Home. (n.d.). Org.uk. Retrieved December 19, 2022, from http://www.tht.org.uk

Home. (2015, April 13). Apoyo Positivo. https://apoyopositivo.org/

Home. (2021, July 9). Healthy Peers; Healty Peers. https://healthypeers.it/

Home. (2022, October 25). Equality Movement. https://equality.ge/en/home

Kim, K., Choi, J. S., Choi, E., Nieman, C. L., Joo, J. H., Lin, F. R., Gitlin, L. N., & Han, H.-R. (2016). Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: A systematic review. *American Journal of Public Health, 106*(4), e3–e28. https://doi.org/10.2105/ajph.2015.302987

Lexx. (n.d.). ГО "АЛЬЯНС.ГЛОБАЛ" – *Сайт громадської організації «АЛЬЯНС.ГЛОБАЛ»*. Net.Ua. Retrieved December 19, 2022, from http://ga.net.ua/en/

Logan, L., Fakoya, I., Howarth, A., Murphy, G., Johnson, A. M., Rodger, A. J., Burns, F., & Nardone, A. (2019). Combination prevention and HIV: a cross-sectional community survey of gay and bisexual men in London, October to December 2016. Euro Surveillance: Bulletin Europeen Sur Les Maladies Transmissibles [Euro Surveillance : European Communicable Disease Bulletin], 24(25). https://doi.org/10.2807/1560-7917.es.2019.24.25.1800312

London Friend - LGBT mental health & wellbeing. (2018, June 8). London Friend. https://londonfriend.org.uk/

Lussier, M. T., & Richard, C. (2007). The motivational interview: in practice. *Canadian Family Physician, 53*(12), 2117–2118.

Mainline - Home. (n.d.). Mainline.Nl. Retrieved December 19, 2022, from https://english.mainline.nl/page/home

Minkler, M. (2005). Community-based research partnerships: Challenges and opportunities. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 82*(2_suppl_2), ii3–ii12. https://doi.org/10.1093/jurban/jti034

Moncrieff, M. (2018). Towards a supportive policy and commissioning environment for chemsex in England. *Sexual Health, 15*(2), 170. https://doi.org/10.1071/sh17188

Page d'accueil. (n.d.). Aides.org. Retrieved December 19, 2022, from https://www.aides.org/

Papathanasiou, N., & Christidi, E. O. (2020). Θεωρητικό πλαίσιο. Επίδραση των διακρίσεων, μειονοτικό στρες, ψυχική ανθεκτικότητα και κοινοτική ψυχολογία [Theoretical Framework. Impact of discrimination, minority stress, resilience and community psychology]. In N. Papathanasiou & E. O. Christidi (Eds.), *Inclusion and Resilience* (pp. 29–69). Gutenberg.

Pepping, C. A., Lyons, A., & Morris, E. M. J. (2018). Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. Psychotherapy (Chicago, Ill.), 55(1), 52–62. https://doi.org/10.1037/pst0000149

Pinkham, S., & Stone, K. (2015). *A Global Review of the harm reduction response to amphetamines: a 2015 update*. Harm Reduction International.

Pires, C. V., Gomes, F. C., Caldas, J., & Cunha, M. (2022). Chemsex in Lisbon? Self-reflexivity to uncover the scene and discuss the creation of community-led harm reduction responses targeting chemsex practitioners. *Contemporary Drug Problems, 49*(4), 434–452. https://doi.org/10.1177/00914509221094893

Pollard, A., Nadarzynski, T., & Llewellyn, C. (2018). Syndemics of stigma, minority-stress, maladaptive coping, risk environments and littoral spaces among men who have sex with men using chemsex. *Culture, Health & Sexuality, 20*(4), 411–427. https://doi.org/10.1080/13691058.2017.1350751

Poulios, A. (2020a). Εισαγωγή στο Chemsex: Από το φαινόμενο στο υποκείμενο [An Introduction to chemsex: From the phenomena to the subject]. In N. O. Papathanasiou & E (Ed.), *Inclusion and Resilience* (pp. 377–402). Gutenberg.

Poulios, A. (2020b). Σεξουαλικότητα και HIV: Gay και Κοινωνικώς Μεταδιδόμενα Νοσήματα [Sexuality and HIV: Gay and Socially Transmitted Diseases]. In N. Papathanasiou & Christidi, & E-O (Eds.), *Inclusion and Resilience* (pp. 342–376). Gutenberg.

QTHC. (n.d.). QTHC. Retrieved December 19, 2022, from http://www.ourhealthyeg.ca

Race, K. (2008). The use of pleasure in harm reduction: perspectives from the history of sexuality. *The International Journal on Drug Policy, 19*(5), 417–423. https://doi.org/10.1016/j.drugpo.2007.08.008

Rahman, A., Nawaz, S., Khan, E., & Islam, S. (2022). Nothing about us, without us: is for us. *Research Involvement and Engagement, 8*(1). https://doi.org/10.1186/s40900-022-00372-8

Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: a systematic review and meta-analysis. *Br J Gen Pract, 55*(513), 305–312.

Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues, 12*(3), 443–449. https://doi.org/10.1080/10481881209348678

Saakvitne, K. W., Gamble, S., Pearlman, L. A., & Lev, B. T. (2000). Risking connection: A training curriculum for working with survivors of childhood abuse. *Xvii, 275*. https://psycnet.apa.org/fulltext/2000-08464-000.pdf

Sexo y Drogas. (2018, October 2). ONG Stop.
https://stopsida.org/sexo-y-drogas/

Shubert, J., Ritchie, E. C., Everly, G. S., Fiedler, N., Williams, M. B., Mitchell, C. S., Langlieb, A. ;. J., Ritchie, E. C., Everly, G. S., Fiedler, N., Williams, M. B., Mitchell, C. S., & Langlieb, A. M. (2007). A missing element in disaster mental health: behavioral health surveillance for first responders. *Int J Emerg Ment Health, 9*(3), 201–213.

Skoun. (n.d.). Facebook.com. Retrieved December 19, 2022, from
https://www.facebook.com/Skoun.org/

Stardust, Z., Kolstee, J., Joksic, S., Gray, J., & Hannan, S. (2018). A community-led, harm-reduction approach to chemsex: case study from Australia's largest gay city. *Sexual Health, 15*(2), 179.
https://doi.org/10.1071/sh17145

Substance misuse services for men who have sex with men involved in chemsex. (2015). *Public Health England*.

Substance use treatment. (2019, March 13). San Francisco AIDS Foundation.
https://www.sfaf.org/services/substance-use-treatment/

Super User. (n.d.). Accueil. Alias.brussels. Retrieved December 19, 2022, from
https://alias.brussels/fr/

Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.
https://doi.org/10.1353/hpu.2010.0233

testBKK. (2022, February 24). Testbkk.org; testBKK.
https://www.testbkk.org/

Thornicroft, G., & Tansella, M. (2003). *What are the arguments for community-based mental health care. Copenhagen: WHO regional Office for europe.*

Trinh, N.-H., Tuchman, S., Chen, J., Chang, T., & Yeung, A. (2020). Cultural humility and the practice of consultation-liaison psychiatry. Psychosomatics, 61(4), 313–320.
https://doi.org/10.1016/j.psym.2020.03.002

Ulrich, H., Grundmann, D., & Sander, D. (2020a). ChemSex: Beschreibung eines neuen Phänomens. *Ärztliche Psychotherapie und psychosomatische Medizin, 15*(2), 101–107.
https://doi.org/10.21706/aep-15-2-101

Ulrich, H., Grundmann, D., & Sander, D. (2020b). ChemSex: Beschreibung eines neuen Phänomens. *Ärztliche Psychotherapie und psychosomatische Medizin, 15*(2), 101–107.
https://doi.org/10.21706/aep-15-2-101

UmEeD – have only positive expectations. (n.d.). Hopecommunity.Pk. Retrieved December 19, 2022, from
https://www.hopecommunity.pk

Vasileiou, A. (2020). Οι δυναμικές ισχύος στη σχέση επαγγελματία ψυχικής υγείας – ωφελούμενου ΛΟΑΤΚΙ+ ατόμου [The power dynamics in the relationship between a mental health professional and an LGBTI+ beneficiary]. In N. Papathanasiou & E. O. Christidi (Eds.), *Inclusion and Resilience* (pp. 141–152). Gutenberg.

What is Chem Sex? (2021, March 26). Rainbow Project.
https://www.rainbow-project.org/what-is-chem-sex/

Wheatley, M. J., & Kellner-Rogers, M. (1998). Bringing life to organizational change. *Journal of Strategic Performance Measurement, 2*(2), 5–13.

Yu, & Cream. (2021, August 5). *GTOWN*. Gtown.Vn.
http://gtown.vn/

(N.d.-a). Sexntina.Nl. Retrieved December 19, 2022, from
http://www.sexntina.nl

(N.d.-b). Retrieved December 19, 2022, from
https://herokhh8f.wixsite.com/myhero

(N.d.-c). Thorneharbour.org. Retrieved December 19, 2022, from
https://thorneharbour.org/lgbti-health/mental-health/therapeutic-groups/

(N.d.-d). Instagram.com. Retrieved December 19, 2022, from
https://www.instagram.com/partybox_ukraine/

(N.d.-e). Regeneracija.org. Retrieved December 19, 2022, from
https://www.regeneracija.org/