London Chemsex Conferences 2024

QUESTIONS AND RESPONSES

While delegates addressed specific questions at the June 2024 conference, delegates attending the October and November conferences were asked to provide their own, generating responses through group discussions.

Questions and responses have been placed under themes. Some questions have been duplicated as they fall under two areas. Not all questions have responses and there are 9 additional unanswered questions, eg: insufficient time or answered elsewhere.

1.0 Culture/ context/ competence

	Question	Response
a.	What are the barriers for chemsex patients when engaging with community drug and alcohol services?	No dual diagnosis commissioning. No tackling of wider/ballistic issues, e.g. housing, benefits, employment. First impressions are everything. Visibility of LGBT plus issues within services, e.g. rainbow stickers. Lack of cultural competence/fear of homophobia/trans phobia from services, and staff. Assessment process can be very lengthy/ 'tick box'. Peer mentors/coordinators might help facilitate access. Bouncing between mental health and addiction services. Drug services set up for heterosexual opioid/alcohol users. Political landscape – health and social care act. Reduce funding for both addictions and sexual health. Totally overlooked services, key workers having too many cases – need more funding. Thinking about turning point/crisis situations. Using this as a facilitator into services
b.	It is challenging knowing where to start. Have you got a to do list for services?	Ways to get Patrick to come and collaborate with us. [xxx] at pathways. Thinking about ways to skill up frontline staff and make them aware of cam sex/related issues. Universal assessment. Hold onto the enthusiasm from today!
c.	How best to ask patient questions related to chemsex?	Non-judgemental. Private space. Treating as human being. Not pathologizing them. Acknowledging what you don't know, being honest, respectful.
d.	How do we overcome the many barriers that this cohort of clients have for them to access treatment?	Disclosure friendly services, training, literature, specialised services, especially open access. Back of toilet doors. Lived experience with staff. Peer focused. Using professionals to present lived experience. Prevent triggering. Language. Find out what barriers – ask!
e.	We know chemsex can facilitate HIV transmission, but how can we support	Having good knowledge of the care pathways and referral routes. Ensuring that frontline staff have the

	people with HIV and their engagement with chemsex?	knowledge and skills to facilitate conversations. Treating people as human beings.
f.	How to support clients who engage in chemsex and are ambivalent about stopping/reducing their use?	
g.	What advice can we give chemsex users about using safely	
h.	How to talk about intimacy without using drugs?	Non-judgemental questions. Open questions. Offer harm reduction advice. Get clients to talk about their sex likes without judgement. Benefits of abstinence counselling.
i.	How best can we support those who are struggling to reduce their use of chemsex drugs due to adverse effects?	More funding for specialist roles within services: A&E, drug services, sexual health, mental health, GP. Harm minimisation. More visibility – wider education. Open groups/satellite clinics from specialist services.
j.	How do we support those engaging in chems to feel safe to access traditional drugs treatment services?	Specialist workers at the first point of access (e.g. A&E, police, LAS, GP, etc). More advertisement on social media/apps, tube, GP/A&E etc. creating welcoming spaces and drop-in clinics.
k.	What information would you give to those who have come in to A&E with harmful sexualised drug use - namely GHB? Is even approaching this subject at this time appropriate or simple discharge with written/ leaflet information more ideal?	Attempt light intervention. Approach with care and without judgement. Keep it simple. Give [Safer] pack info. Harm minimisation card (LAS). Sexual education. Give info on alcohol and G use. Ask when they did last use/ withdrawal + what does their use look like.
l.	What is the most challenging aspect of educating people on risks of chemsex?	Stigma. Talking about sex and drugs. People feeling they are already protected against HIV, etc. Not demonising drug use. Criminalisation of drug use, can be a barrier to education.
m.	Resources for youth?	Youth led organisations. Social media. Education for professionals. Hidden harm. Education around prevention and harm reduction. Anonymous.
n.	Are mainstream drug and alcohol services and mental health services currently failing to provide adequate care for chemsex users?	
o.	Why is chemsex so prevalent in certain communities?	
p.	Are providers of services talking about consent as part of their work?	Yes – we are for consent in terms of confidentiality. Yes – in terms of informed consent in the context of sex and sexual acts. Yes: ask the person about discussing the issue. Some A&E test HIV without consent. No/yes: during the chemsex. Actions: create awareness for [xxx] to ask for consent.
q.	What can sexual health professionals do to challenge their own biases when supporting adults engaged in chemsex?	Acknowledge judgement. LISTEN. Park your judgement to not impair practice.
r.	Correct terminology when speaking with clients	-VE (Avoid). Shame. Blame. +VE: empathy. Curiosity. Nonjudgemental. Care. How can I help you? What brings you here? Handholding listening open “gender affirming”. Allow silence. No assumptions. “Tell me more about that”. How that feels the you/ impacts you. [xxx]
s.	How can we enhance research, treatment, and policy around the combination of chemsex with IPEDs e.g. anabolic steroid use?	Start in schools – early intervention, raising awareness, doing projects. Thinking about what body dysmorphia/ED’s. More research into minorities e.g.: religious groups and early trauma –

	how difficult it is to find help from these communities. Raising awareness within communities. Being aware of intersectionality. Diversity in research. People with lived experience into policy + research worlds. Thinking about effects of online cultures/social media communities, e.g.: steroid use. Partnerships with social media influences, e.g.: steroid users/gym trainers. Promote Love Tank's guide to steroids for LGBTQ+. Being aware of chemsex recovery may lead to weight gain – this may be a barrier to treatment and recovery. More money for drug dual diagnosis practitioners and work with this. Encourage routine enquiry, e.g.: steroid use.

2.0 Data

	Question	Response
a.	How to measure prevalence?	Formal population -weighted research studies (very expensive). Drug and alcohol services routine data collection. Political pressure to change NDTMS data collection and research chemsex specifically. Outreach/data collection in more marginalised communities: non-mail, Trans, non-binary, fetish, sex party. Triangulate data from multiple sources/agencies, e.g.: DV, health, homelessness
b.	What are the current stats for chem sex incidents and fatalities	
c.	Is this an opportunity to include specific chemsex KPIs/ performance indicators/ partnership working at a national level?	Yes, no paperwork/ box ticking but data collecting Young persons service for chemsex. Please. [Name deleted] from RISE.
d.	How far has this developed into the heterosexual/ swinging communities?	Websites such as Fab guys stop not gay like grinder. MSM/married/retro. Female. Trans – using it for work, delay in orgasm, lasts for days equals more punters. More research is needed into heterosexual chemsex – as they may not see themselves as part of the community. Female sex workers have been to be using. Couples using together. Hetero female using in swinging parties, etc. Trans women, pre-op – heterosexual men. [xxx]

3.0 Funding/ commissioning

	Question	Response
a.	Are there any opportunities for Third Sector Organisations to run grant funded schemes to manage risk in this cohort?	Problem of competing for same pot of funding. Competition rather than collaboration between services. Third sector orgs can be getting research/ small projects done – good access to participants. Relying on insufficiently trained people manage risk can be disastrous. Risk management is a very specialist skill – need to ensure appropriate safeguarding. Processes, audit, etc.
b.	Why did we still no move to models of integrative commissioning in dual diagnosis?	Some Trust have started the integration (dual diagnosis but not funded/ implemented fully. Lack of awareness of needs. We need integration, education, change the curriculum. Funding. Stigma, taboo. Consultant only dealing with psychosis. Operational/systems/dialogue. Funding/resources. Training. Different remits. High caseloads. Social bias needs to be challenged. Pressures.

		Actions: education: change the curriculum. Create awareness. Integrated education programme.
c.	How can we get those who use chems into non specialist services?	Apps – websites. Grinder. BBRT. Squirt. Scruff. Kink pigs. Sexual health clinics. HIV services. (Issues around medical records). Training for ALL. Frontline and above staff. Ambulance service [xxx]. Sex worker organisations. Homelessness. BAME organisations. Trans and non-binary. [xxx]. Partnership working and collaboration (especially with GMAC). Staff training, re: cultural competence for LGBTQ+. Specialist LGBTQ+ or cam sex workers in mainstream drug services, able to use correct language. Normalise talking about sex in all healthcare contexts. Need to treat both drugs/Chems and sex problems together. Outreach, e.g.: sex on premises/venues. Offering a range of options/services. Services being as anonymous as possible. Services being generally accessible, e.g.: evening opening.
d.	What is the single most important thing we could do to raise the profile of the importance of chemsex services?	Reduced to boom. Humanise those impacted. Yet government to wake up. Funding.
e.	What is happening to help make chemsex support less dependent on the part of the country you live?	
f.	How can we ensure reps of key community organisations are present?	Organisations. Sexual health and mental health. Difficult to complete MDT [multidisciplinary teams] with all key organisations.
g.	How can we improve access to mental health support for chems users?	To actually have mental health services. The key to the door. What do we mean by mental health. Stigma around mental health. Lack of diagnosis/ treatment. Recovery and loss of libido – intimacy – trap door of recovery. After care – dealing [xxx can't read]. Lack of ownership: drug and alcohol v mental health.

4.0 Harm reduction/ outreach

	Question	Response
a.	How to support clients who engage in chemsex and are ambivalent about stopping/reducing their use?	
b.	What advice can we give chemsex users about using safely	
c.	What is the best way to reach out to MSM as we find it hard to reach that cohort.	Targeted advert on apps like Grindr. Information in most sexual health clinics. Outreach in saunas and clubs. Give safety packs in clubs. Actions! Campaigns, events related to above (talk about harm reduction, safe sex).
d.	How to talk about intimacy without using drugs?	Non-judgemental questions. Open questions. Offer harm reduction advice. Get clients to talk about their sex likes without judgement. Benefits of abstinence counselling.
e.	How best can we support those who are struggling to reduce their use of chemsex drugs due to adverse effects?	More funding for specialist roles within services: A&E, drug services, sexual health, mental health, GP. Harm minimisation. More visibility – wider education. Open groups/satellite clinics from specialist services.
f.	Is there a rehab to support with problematic sex/relationship behaviours?	Not funded by XXX Council. Private provider? Meetings yes.
g.	How do we support those engaging in chems to feel safe to access traditional drugs treatment services?	Specialist workers at the first point of access (e.g. A&E, police, LAS, GP, etc). More advertisement on social media/apps, tube, GP/A&E etc. creating welcoming spaces and drop-in clinics.
h.	What information would you give to those who have come in to A&E with harmful sexualised drug use - namely GHB? Is even approaching this subject at this time appropriate or simple discharge with written/ leaflet information more ideal?	Attempt light intervention. Approach with care and without judgement. Keep it simple. Give [Safer] pack info. Harm minimisation card (LAS). Sexual education. Give info on alcohol and G use. Ask when they did last use/ withdrawal + what does their use look like.

i.	What tools can we use to screen or risk stratify a chemsex user to then advise on referral to addiction services?	We need a screening tool xxx AUDIT A tool to access GBL withdrawals such as COWS (Clinical Opiate Withdrawal Scale) Paraphernalia. Needle exchange that encourages chemsex users to attend. Give out PIP PACs.
j.	What is the best way to get harm reduction messaging to the community?	
k.	Where can you direct clients into getting a safer chemsex pack?	
l.	How best to support clients who with multiple health problems and who disengage with services?	Seeing people where they are. Flexible practice (XXX), prioritise, peer support model, varied practice (outreach, online, face-to-face, phone, weekend)
m.	Is there a strategy or any data around assessing the scope of need from chemsex users, using solo on cam to cam encrypted services like Telegram and the associated harm, eg: revenge porn, blackmail, grooming of children/YPs extortion etc.	Think like a drug dealer. Act like an algorithm. Bot! Act like a porn content creator

5.0 Knowledge/ learning

	Question	Response
a.	How far has this developed into the heterosexual/ swinging communities?	Websites such as Fab guys stop not gay like grinder. MSM/married/retro. Female. Trans – using it for work, delay in orgasm, lasts for days equals more punters. More research is needed into heterosexual chemsex – as they may not see themselves as part of the community. Female sex workers have been to be using. Couples using together. Hetero female using in swinging parties, etc. Trans women, pre-op – heterosexual men. [xxx]
b.	What is the most challenging aspect of educating people on risks of chemsex?	Stigma. Talking about sex and drugs. People feeling they are already protected against HIV, etc. Not demonising drug use. Criminalisation of drug use, can be a barrier to education.
c.	Resources for youth?	Youth led organisations. Social media. Education for professionals. Hidden harm. Education around prevention and harm reduction. Anonymous.
d.	Would marijuana be considered a substance influencing sexual behaviour?	
e.	Is there are a north/south divide about the openness of attending chem sex parties?	
f.	What is the root cause of chemsex?	
g.	Why is crystal meth in particular linked with chemsex?	Makes you horny / aroused Energy / stamina Inhibitions ↓ Allows to have sex – with others [you] wouldn't consider Makes me feel more attractive Animal instinct ↑ Easy to find to find and easy to use Heavily promoted on apps 'It's a gay thing' – in UK
h.	Are all drugs classes as chemsex?	
i.	What are the main drug trends within the chemsex scene?	Crystal meth/ GBL/ GHB/ mephedrone (cocaine/ MDMA/ alcohol). Risk of OD.
j.	Is the ease of getting GBL fuelling the increase in health related incidents?	Yes – we see at least 5 patients per week in G withdrawal (A&E).
k.	Are mainstream drug and alcohol services and mental health services currently failing to provide adequate care for chemsex users?	
l.	Why is chemsex so prevalent in certain communities?	

m.	Is it time we redefine chemsex to include other drugs that affect parts of not just the LGBTQ+ community but those beyond it?	
n.	How similar is the stigma and shame from chemsex and HIV?	
o.	Are there any women that engage in chemsex?	Yes – Hetro, Bi, Trans, Non-Binary, Gender Diverse As a couple/ group
p.	Are providers of services talking about consent as part of their work?	Yes – we are for consent in terms of confidentiality. Yes – in terms of informed consent in the context of sex and sexual acts. Yes: ask the person about discussing the issue. Some A&E test HIV without consent. No/yes: during the chemsex. Actions: create awareness for [xxx] to ask for consent.
q.	What do we have in Croydon to support LGBT clients?	Soho. Central. Local. Services are either pan- London. Do you need to avoid your Borough. Hybrid options online.
r.	Managing withdrawals in an inpatient setting.	Managing Baclofen. Used for G withdrawal. Clear detox plan written by ACCS (Addiction Clinical Care Suite) – only inpatient service in London to detox. Continue to have issues around testing – unable to detect.
s.	What can sexual health professionals do to challenge their own biases when supporting adults engaged in chemsex?	Acknowledge judgement. LISTEN. Park your judgement to not impair practice.
t.	Correct terminology when speaking with clients	-VE (Avoid). Shame. Blame. +VE: empathy. Curiosity. Nonjudgemental. Care. How can I help you? What brings you here? Handholding listening open "gender affirming". Allow silence. No assumptions. "Tell me more about that". How that feels the you/ impacts you. [xxx]
u.	How can we enhance research, treatment, and policy around the combination of chemsex with IPEDs e.g. anabolic steroid use?	Start in schools – early intervention, raising awareness, doing projects. Thinking about what body dysmorphia/ED's. More research into minorities e.g.: religious groups and early trauma – how difficult it is to find help from these communities. Raising awareness within communities. Being aware of intersectionality. Diversity in research. People with lived experience into policy + research worlds. Thinking about effects of online cultures/social media communities, e.g.: steroid use. Partnerships with social media influences, e.g.: steroid users/gym trainers. Promote Love Tank's guide to steroids for LGBTQ+. Being aware of chemsex recovery may lead to weight gain – this may be a barrier to treatment and recovery. More money for drug dual diagnosis practitioners and work with this. Encourage routine enquiry, e.g.: steroid use.
v.	What are the barriers for chemsex patients when engaging with community drug and alcohol services?	No dual diagnosis commissioning. No tackling of wider/ballistic issues, e.g. housing, benefits, employment. First impressions are everything. Visibility of LGBT plus issues within services, e.g. rainbow stickers. Lack of cultural competence/fear of homophobia/trans phobia from services, and staff. Assessment process can be very lengthy/ 'tick box'. Peer mentors/coordinators might help facilitate access. Bouncing between mental health and addiction services. Drug services set up for heterosexual opioid/alcohol users. Political landscape – health and social care act. Reduce funding for both addictions and sexual health. Totally overlooked services, key workers having too many cases – need more funding. Thinking about turning point/crisis situations. Using this as a facilitator into services
w.	Is there any specific guidelines for assessment of patient presented ED intoxicated of G and other party drugs?	Joint working between mental health and addiction services/toxicology. Patient needs to be able to engage in mental health assessment (i.e. not intoxicated). Withdrawal management once able to facilitate bio-psychosocial assessment. Better education for A&E triage nurses!
x.	Do medical professionals and partners have fears that we might be close to a public health	In A&E, at weekends there is a peak of overdose chemsex, and requests for an ambulance. More in inner cities. The more

	tipping point/watershed moment in regards to chemsex and its current scale/reach?	society accepts the more the increase in use. Actions/suggestions: create an AA for chemsex. Education.

6.0 Service provision/ integrated pathways

	Question	Response
a.	How best to support clients who with multiple health problems and who disengage with services?	Seeing people where they are. Flexible practice (XXX), prioritise, peer support model, varied practice (outreach, online, face-to-face, phone, weekend)
b.	Why did we still no move to models of integrative commissioning in dual diagnosis?	Some Trust have started the integration (dual diagnosis but not funded/ implemented fully. Lack of awareness of needs. We need integration, education, change the curriculum. Funding. Stigma, taboo. Consultant only dealing with psychosis. Operational/systems/dialogue. Funding/resources. Training. Different remits. High caseloads. Social bias needs to be challenged. Pressures. Actions: education: change the curriculum. Create awareness. Integrated education programme.
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d.	How can NHS services improve in their offer of support?	Yes. All would all providers, third sector. Schools, Youth clubs, Apps
e.	Is there any specific guidelines for assessment of patient presented ED intoxicated of G and other party drugs?	Joint working between mental health and addiction services/toxicology. Patient needs to be able to engage in mental health assessment (i.e. not intoxicated). Withdrawal management once able to facilitate bio-psychosocial assessment. Better education for A&E triage nurses!
f.	It is challenging knowing where to start. Have you got a to do list for services?	Ways to get Patrick to come and collaborate with us. [xxx] at pathways. Thinking about ways to skill up frontline staff and make them aware of cam sex/related issues. Universal assessment. Hold onto the enthusiasm from today!
g.	We know chemsex can facilitate HIV transmission, but how can we support people with HIV and their engagement with chemsex?	Having good knowledge of the care pathways and referral routes. Ensuring that frontline staff have the knowledge and skills to facilitate conversations. Treating people as human beings.
h.	What is the best way to reach out to MSM as we find it hard to reach that cohort.	Targeted advert on apps like Grindr. Information in most sexual health clinics. Outreach in saunas and clubs. Give safety packs in clubs. Actions! Campaigns, events related to above (talk about harm reduction, safe sex).
i.	Is there a rehab to support with problematic sex/relationship behaviours?	Not funded by XXX Council. Private provider? Meetings yes.

7.0 Strategy/ planning

	Question	Response
a.	Is there a strategy or any data around assessing the scope of need from chemsex users, using solo on cam to cam encrypted services like Telegram and the associated harm, eg: revenge	Think like a drug dealer. Act like an algorithm. Bot! Act like a porn content creator

	porn, blackmail, grooming of children/YPs extortion etc.	
b.	Why hasn't chemsex been picked up by public health commissioners?	Taboo subject. Was seen as low and seedy. Not seen as priority. Might not cost the government money. No crime → ?
c.	What is the single most important thing we could do to raise the profile of the importance of chemsex services?	Reduced to boom. Humanise those impacted. Yet government to wake up. Funding.
d.	What is happening to help make chemsex support less dependent on the part of the country you live?	
e.	How can we ensure reps of key community organisations are present?	Organisations. Sexual health and mental health. Difficult to complete MDT [multidisciplinary teams] with all key organisations.
f.	How can we improve access to mental health support for chems users?	To actually have mental health services. The key to the door. What do we mean by mental health. Stigma around mental health. Lack of diagnosis/ treatment. Recovery and loss of libido – intimacy – trap door of recovery. After care – dealing [xxx can't read]. Lack of ownership: drug and alcohol v mental health.
g.	Do medical professionals and partners have fears that we might be close to a public health tipping point/watershed moment in regards to chemsex and its current scale/reach?	In A&E, at weekends there is a peak of overdose chemsex, and requests for an ambulance. More in inner cities. The more society accepts the more the increase in use. Actions/suggestions: create an AA for chemsex. Education.
h.	How can NHS services improve in their offer of support?	Yes. All would all providers, third sector. Schools, Youth clubs, Apps

Unanswered questions

1. Any chance of exploring detection of g use
2. Is using fear-based approaches an effective or ethical method to prevent chemsex, or does it risk further stigmatizing individuals and driving the behavior underground?
3. I find it deeply tragic hearing stories from those with lived experiences in the chemsex scene. I struggle with the concept of promoting harm reduction in such devastating circumstances. How do we justify harm reduction approaches while still acknowledging the severe impact on individuals' lives? And how do we prevent society from conflating the chemsex community with the entire gay community, thus perpetuating harmful stereotypes?
4. Given the risks involved, particularly to mental and physical health, is it reasonable to advocate for abstinence as a prevention strategy in chemsex, or does that approach risk alienating individuals who may need harm reduction support?
5. How can we better emphasize the devastating impact chemsex can have on mental health in public health campaigns, while ensuring that we provide compassionate support rather than contributing to stigma?
6. Given that chemsex represents a small minority within the LGBTQ+ community, how can we ensure that public health discussions and media portrayals don't inadvertently generalize or stigmatize the entire gay community as participating in chemsex?
7. What are the most dangerous substances to mix with crystal meth?
8. How do we navigate the balance between respecting personal autonomy in chemsex while addressing the moral and ethical concerns that arise from potential harm, both to individuals and the broader community?
9. Is there an equivalent to the AA model specifically for chemsex (Crystal meth) and how effective has it been in supporting recovery?