European ChemSex Forum

6-8 April 2016

Congress Centre, London

FORUM REPORT

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INTRODUCTION

The European ChemSex Forum, 6-8 April 2016, London, UK was a preliminary intelligence gathering and networking event aiming to provide a platform to engage in international, cross-sector, multi-disciplinary dialogue and discussions around ChemSex – defined by the use of specific drugs ("Chems") in a sexual context by Men who have Sex with Men (MSM), Transgender people and any other population disproportionately affected by HIV, hepatitis C and other sexually transmitted infections. The Forum was hosted by 56 Dean Street, GMFA, ReShape, International HIV Partnerships (IHP) and Professional Briefings, with the support of Gilead, ViiV Healthcare, Abbvie and AIDES and endorsed by the European AIDS Treatment Group, HIV in Europe and AIDS Action Europe.

Data from recent UK studies showing that ChemSex could be a contributory factor to HIV in gay men have been complemented by reports from sexual health and drug practitioners in many European countries, indicating a rise in the use of drugs associated with ChemSex, and an increase in the number of men presenting at sexual health and drug services with problematic experience of drug use. As well as the very obvious public health concern of HIV, hepatitis C and sexually transmitted infections, ChemSex has been associated with overdoses, suicides, addiction, psychoses/poor mental health, as well as influencing concepts of sexual and cultural identity and wellbeing. An increase in injecting trends among people naive about injecting risks has also been observed. Consequently, there is an urgent need to coordinate efforts with services across Europe to identify and monitor these trends, especially in view of increasing population migration and cross-borders sex tourism.

In this context, the Forum aimed:

- to identify the key trends across Europe;
- to share good practice, challenges and examples of effective community responses; and
- to provide some of the developing answers to ensure the sexual health and wellbeing of gay men and other men who have sex with men.

200 participants took part in the Forum over three days, bringing together healthcare providers, researchers, therapists, policy makers, service providers and service users from 26 European countries. The Forum started with a training day for 65 frontline staff from the WHO European region and was followed by two full days of presentations and discussions, with Day One looking at data and evidence across Europe and Day Two focusing on the community response to ChemSex. In addition, over 2200 respondents participated in the pre-conference awareness survey “Horizon impression” from 33 European and Central Asian Countries.

The Forum included presentations, panels, debates and poster displays allowing participants to engage in rigorous information exchange. The community and services response was complemented with the screening of ChemSex-related videos, a photographic exhibition and community and service information stands. Educational events, demonstrating the

London and UK response to ChemSex, also took place over three evenings. The agenda is provided in the appendix.

This meeting report synthesises and summarises the proceedings and outcomes of the European ChemSex Forum and has been prepared by the organising committee in consultation with key partners.

The Forum presentations are available at:
http://www.slideshare.net/Checkpoints14/presentations

The Forum posters are available at:
https://drive.google.com/folderview?id=0B9E_UBugz0VVZXloSFdqekRxS2M&usp=sharing

Audio files with slides presentations are available at:
https://www.youtube.com/playlist?list=PLF-szL8WntiUXDHITYLwpFYNLOUr-lyXd

DATA / EVIDENCE DAY

OPENING SPEECHES

The Forum was opened by Bryan Teixeira, Meeting Chair, and included speeches by James Beckett, Chelsea and Westminster General Manager for HIV/GUM, Pathology and Dermatology and 56 Dean Street, Matthew Hodson, GMFA Executive Director and Ben Collins, IHP Director and ReShape Convenor.

Bryan Teixeira, Meeting Chair, welcomed participants to the first gathering of the Chem-Sex Forum and explained that Day 1 would be mainly centred around the gathering of evidence and data from across Europe and Day 2 would be about community responses and mobilisation around ChemSex.

James Beckett warmly welcomed participants to London and opened his address with a brief history of Chelsea & Westminster Hospital: 7 sexual health clinics around London with various level of prevalence for ChemSex with 56 Dean Street Clinic opening in 2008. The clinic was moved from its original location in Pimlico to Soho as more cases of HIV were found in a short session there than in an entire week in Pimlico. He stressed the importance of moving away from traditional sexual health clinics to thinking about well-being more broadly. Giving people the opportunity to have an honest conversation about sex and the issues they were having specifically around ChemSex was key. The 56 Dean Street model showed that even within the context of the NHS, services could be nimble, innovative and move quickly to adapt to the needs of local communities. A combination of innovation and passionate and dedicated staff was the key to success rather than financial resources.

Matthew Hodson, thinking specifically as to why forum participants were here today, stated that stories of people passing away as a result of their ChemSex use were becoming more frequent and that it reminded him of the early days of HIV when "*first it was a friend of a friend, then it was a friend and then it was you"*. The Forum heard that the challenges of ChemSex were incredibly complex and that we needed to rise to meet that challenge and realise that there will be no single magic bullet to answer it all. The questions to consider at this meeting were: Is it a problem, what is the scale of the problem, and how many people who use Chems have problems with their Chems use. We still lack the robust data to answer those questions. We also need to be asking what should we be doing? There are legal, social, supporting ways to respond to this challenge. Finally, we should also be asking ourselves: what can *I* do?

Ben Collins gave an overview of the demographics among the participants. 450 people applied for the 200 forum spaces and 200 people applied for the 65 training spaces. To allow for a wide representation across Europe, many people in the UK had not been able to register and the organising committee apologised for this. 26 countries across Europe were represented, 23 posters had been submitted, and 2200 people had answered a pre-conference survey on ChemSex. The Forum's organisers will be working with people at country level to explore the results. Dialogue has already started with people on the continent to move the next Forum nearer to Eastern Europe and Central Asia, to facilitate their participation.
This overwhelming response showed how much people wanted to talk about ChemSex. He called for all participants to help develop further work and to make this a truly intersectoral conference.

THE CHEMSEX CHALLENGE: OVERVIEW OF LONDON /UK EXPERIENCE
David Stuart Forum Chair, 56 Dean Street

David Stuart gave an historical overview of ChemSex in the UK, and started by explaining that the word "Chems" had been around for a while, generally used by people who wanted particular drugs but were too scared to use the word "drug" on early online platforms.

In 2002, there were no Crystal Meth dealers, but cabin crews would bring the drug from other countries. A small group of gay men took it in saunas, Grindr was not around yet. However, the harm was minimal; there was no rush to clinics or spikes in HIV or STIs or physical addictions. Things started to change almost overnight with the introduction of GHB/GBL. At the same time, technology was changing the way gay men hooked up.

By 2010, people were coming into the PEP clinic regularly after drug fuelled weekends. Sexual health clinics staff was not yet equipped to deal with drug problems and did not know how to do risk assessment and ask the right questions. The Club Clinic opened its doors and invited Antidote to be part of it, integrating drug and LGB&T wellbeing services.

Meanwhile, other challenges presented themselves: Gay communities escaping the horrors of the HIV epidemic had normalised less problematic drugs, but new drugs flooding gay markets and scenes were considerably more harmful, and many gay men and health services were naïve of these dangers. The change was so quick, the gay press was struggling to talk about ChemSex, and people were still having a great time with their drugs and did not want to talk about it either.

The double challenge of easy access through hook-up apps and the arrival of new and harmful drugs would redefine the way we look at harm reduction in a sexual health context.

Today, 3.000 gay men using Chems access 56 Dean Street each month. Between 20 to 30 regular Chem users are diagnosed with HIV every month, and PeP is prescribed to approximately 300 gay men a month following a ChemSex episode.

New challenges have appeared: issues of consent, with people passing out from drug use; multiple partners during single, but very extended sex sessions; people not identifying risks and thinking this is all a normal part of their sex life. The last challenge is to raise this issue of sexual well-being. Gay sexual liberation was defined defiantly through the AIDS years as the right to have sex with whoever we want, with as many partners as we like, as frequently as we like, without fear of "slut-shaming" or being encouraged into hetero-normative roles; we may need to redefine this a having a multitude of shame-free/stigma-free options to enjoy sex-lives that are informed by a robust sense of self-worth, and an understanding of our sexual and emotional needs.

London is one of the few big cities without a LGBT centre. People walk into 56 Dean Street as if it was a community centre. This prompted the start of the Dean Street Well-Being Programme, with events, film screenings etc. Sexual health services need to be able to discuss intimacy, the joy of sex, the roles sex and intimacy play in our broader lives and the sexual and emotional needs of gay men and their general well-being in modern times and contexts.

David ended the session by inviting Forum attendees to join the Organising Committee in a moment of silence, to remember the many gay men who had lost their lives to ChemSex related harms.

TOWARDS A CHEMSEX MAP: OVERVIEW OF DATA AND EVIDENCE

Dr. Adam Bourne London School of Hygiene and Tropical Medicine

Dr Adam Bourne provided a snapshot of the available data and evidence on ChemSex. He looked at the history of drug use among MSMs and at the context of drug use before the emergence of ChemSex as well as the social and cultural context of ChemSex and the role of ChemSex in sexual health and broader well-being.

Key points:

- Traditionally, gay men have used drugs more commonly than heterosexuals. Patterns of drug use across the world show that drug use is episodic, with wide variations by demographic groups and HIV testing history. Polydrug use is common and injection drug use is low. Over the last 5 years, there has been a migration from older drugs to new drugs: mephedrone, GHB/GBL, crystal meth and ketamine. Injection drug use is a new behaviour amongst MSM and there is an acute need for safe injection advice.
- Many of the facilitators of ChemSex are technological and structural, with the migration towards the new drugs due to market economics (lower cost and better accessibility) and access and uptake for sex facilitated by GPS sexual networking apps, as well as wide spread access in gay male sex on premises venues.
- MSM engaging in ChemSex are more likely to report unprotected anal intercourse, to have higher rates of recent STI diagnosis and to have a higher number of casual sex partners. They can be broadly separated into 3 main groups: men engaging in Chem-Sex but maintaining safer sex behaviour; men engaged in pre-determined unprotected anal intercourse (serosorting); men engaging unintentionally in risk behaviour while under the influence of drugs. Generally there is an association between the use of an illicit substance and an increased likelihood of reporting sexual risk behaviour.
- ChemSex has a significant impact on mental health and on physical health.
- ChemSex tends to accelerate following HIV diagnosis, relationship break up or following migration to London.

CONCLUSIONS: WHAT WE NEED TO KNOW

- How prevalent is ChemSex among MSM?
  - Current drug use prevalence; sub-group analysis by demographic and psychographics.
- What is the impact of ChemSex on sexual health and well-being?
  - Influence of drug use on HIV/STI acquisition; impact over time on other sexual health indicators.
- What motivates and/or facilitates engagement in ChemSex?
  - Personal, social and contextual factors influencing the emergence of sexualised drug use and establishment and propagation of drug use norms.
- What works to minimise harm associated with ChemSex?
  - Assessment of effectiveness of interventions addressing sexual, physical and mental health needs.

CHEMSEX ACROSS EUROPE: WHAT'S KNOWN AND WHAT'S NOT

Axel J. Schmidt London School of Hygiene and Tropical Medicine
Niels Graf and **Anna Dichtl** Frankfurt University of Applied Sciences

Axel J.Schmidt presented some of the data from EMIS (The European MSM Internet Sex Survey) from 2010, giving an overview of ChemSex drug use among MSMs in 44 major European cities. Results of this survey included the generic use of ChemSex-defined drugs (crystal methamphetamine, mephedrone, GHB/GBL and ketamine), though did not specifically survey the use of these drugs in sexual contexts. He looked specifically at time trends in Germany, comparing 2010 and 2013 data and explored ChemSex related hypotheses based on this data.

Key points:

- The use of ChemSex-defined drugs was most prevalent in UK cities (40% of MSMs had used ChemSex drugs at some point) and use of drugs associated with ChemSex varied substantially across European cities. In Brighton, UK, the odds of taking ChemSex drugs in the past 4 weeks were 11 times higher than in German cities.
- ChemSex drugs were often combined with Viagra. Ketamine use had been replaced in the UK in the last 12 months by different drugs, while mephedrone was not an issue in many cities, except in the UK where it was introduced around 2009. Amphetamine use was more prevalent in techno-culture cities. Poppers use matched very closely sex and alcohol recency curves.
- The strongest demographics predictors of ChemSex use were firstly the city of residence followed by HIV diagnosis and a high number of partners. Age played a minor role, with hardly any differences in use until the age of 40 where it dropped slightly.
- In Germany there were no significant changes in cocaine use between 2010 and 2013 and a very slight increase in crystal meth use (+0.12% each year) and a slight increase in Ketamine and GHB/GBL (+0.19%). There were no significant trends in the use of chemical drugs, however the patterns of drug consumption and the type of drugs have changed.
- The use of ChemSex-defined drugs tends to accelerate immediately after HIV diagnosis, especially in the first year of diagnosis (17.1% after one year in the UK and 9.25% in other European cities).
- The use of ChemSex-defined drugs tends to accelerate following MSMs sex tourism, independently of the destinations.

Niels Graf and Anna Dichtl focussed their presentation on ChemSex prevalence in Germany, looking in particular at the social contexts, at the motivations behind sexualised drug use and at the impact of ChemSex on well-being. They also explored the impact of drug use on services and the requirements of an effective support system.

Key points:

- In Germany, sexualised drug use is a minority behaviour and tends to be episodic. Most MSMs interviewed reported controlled use of drugs with a minority reporting more regular instances and difficulties in controlling their drug use. These men tended to be older and less experienced with drugs. Slamming was not very common. None of the men perceived themselves as drug addicts.
- MSMs engaging in ChemSex tended to be well-educated, in employment and well paid, in contrast to images of traditional drug use. Sexualised drug use was more common in larger cities, among younger MSMs and among MSMs diagnosed with HIV.
- The motivations for sexual drug use were both physical, with the enhancement and intensification of sexual performance and psychological, with the reinforcement of com-

munication skills and the strengthening of self-confidence. All these aspects emphasise the importance of underlying social and community norms.

- The more problematic MSMs considered their drug use to be, the more they reported negative consequences on their well-being, ranging from erectile dysfunction to unintended loss of control and associated risk-taking behaviours. However, most men also reported positive aspects, such as very intense and extended sexual experiences.
- From the perspective of drug-using MSMs, to be acceptable to them, services must show acceptance of both their homosexuality and their drug use and should be embedded in the sexual health sector rather than the drug treatment sector. Currently 2 German cities offer specific support for drug-using MSMs, however there is no integrated support system so many gaps still need to be filled.

CONCLUSIONS: WHAT WE NEED TO KNOW

- When is controlled drug use possible, what could effective risk management strategies look like and what are the relevant factors driving change in drug use?
- What role do social and community norms play in the context of ChemSex?
- How can commonalities and differences of ChemSex patterns be explained?
- What could satisfying sober sex be like and under which conditions can it occur?
- Is ChemSex onlv of concern for MSM?

PLENARY DISCUSSION

Continuing with the theme of the morning on ChemSex across Europe, the plenary discussion aimed to foster a broad and meaningful dialogue on issues of MSMs drug use, services response and ChemSex prevalence, as raised by the presentations.

SESSION PARTICIPANTS

Chair : Bryan Teixeira

Panellists :

- *James Beckett, Chelsea and Westminster*
- *David Stuart, 56 Dean Strett*
- *AdamBourne, LSHTM*
- *Axel J. Smith, Swiss Federal Office of Public Health*
- *Niels Graf, Frankfurt University of Applied Sciences*
- *Anna Dichtl, Frankfurt University of Applied Sciences*

KEY THEMES OF THIS SESSION

- *Motivations for drug use are difficult to identify but are similar to alcohol use: low self-esteem, HIV status etc., highlighting the need for support and for addressing these issues.*
- *Access to specialist services, where people feel comfortable speaking about their sexuality and/or drug use, is key.*
- *MSM do not perceive themselves as drug addicts and do not want to access mainstream drug services.*
- *Patterns in ChemSex and differences between East and West are probably due to the availability of drugs as well as access to settings (saunas, clubs).*
- *Sexualised drug use tend to involve more than one drug but little is known about interactions and harms of various combinations (including HIV drugs)*

"OH THOSE BOYS..." AN HISTORICAL PERSPECTIVE ON SEX AND DRUGS IN GAY MEN'S LIVES

Leon Knoops, Mainline
Bernard Kelly, Courtyard Clinic, St Georges University Hospital

This session explored the role drugs have played in gay men's life throughout history.

Leon Knoops opened the session by talking about some of the outreach work currently being conducted in Amsterdam, focusing on the club scene, where drug use is very popular. In 2011, the first indications of an increase in crystal meth use appeared in Amsterdam. The first interviews with MSM taking these drugs showed that gay men were not very aware of the risks so a booklet on the dos and don'ts of slamming was produced, containing objective information and non-judgemental language. Interviews with ChemSex participants showed that drugs were used in very different ways: Some MSMs were very prepared, going to parties where all aspects were controlled (such as knowing the HIV status of the participants'), while others had no control at all. Similarly, the motivations behind drug use seemed to vary greatly, some simply enjoyed it because it was a powerful experience, for others, internalised homophobia played a big a part.

Bernard Kelly stressed that gay men had a very recent catastrophe just behind them, with a huge amount of death and loss, which was very rarely talked about today. He stated that "*we were not post-AIDS, we were post mass-death*". Gay men have a very particular relationship with death and risk and although we have this historical context of deaths, we now have new deaths, which are not recorded and counted. It is reaching the point where people are leaving London to get away from drugs, like coming out of a war zone.

Oscar Wilde's Dorian Gray portrays a young sexy man about town with a terrible picture of himself in the attic he cannot face. In ChemSex, that picture has burst out of the attic and gay men have to face certain things in themselves: in 2013, a survey conducted by Stonewall found that half of gay and bisexual men felt their lives were not worth living (compared to 17% in men in general). In 2012, 3% attempted suicide (rising to 5% in black and ethnic minorities) compared with 0.4% of men in the general population.

> "Being traumatised means continuing to organise your life as if the trauma was still going on, unchanged and immutable, as if every new encounter or event is contaminated by the past. After trauma the world is experienced with a different nervous system. The survivor's energy now becomes focussed on suppressing inner chaos at the expense of spontaneous involvement in their lives" Besser van der Kolk

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we face and explore the darkness within ourselves without being consumed by it?

There has been a long struggle with building communities and gay men often find interesting and strange ways to create bounds together. As Kico Govantes thought in "And the Band Played on": "It is ironic that a community so entirely based on love should create institutions so entirely devoid of intimacy". The challenge is how to create spaces where people have a particular sense of belonging.

History tends to repeat itself and the consequences of ignoring these challenges cannot be grimmer. The community has often dealt with problems coming along, be it HIV or ChemSex, by first denying there was problem. Then there is recognition of the problem and a quick response: the problem is we are not having enough sex, or pleasure, or freedom. The third stage is to pretend there isn't a problem, then ultimately the problem bursts out and we wonder how the problem got so big.

CLINICAL PERSPECTIVES

1. The brain and addiction

Philippe Batel, Clinique Montevideo

In his talk Phillipe Batel introduced the Forum to some basics of the neurobiology of addictive disease. He began by mentioning how several models of addiction were established in the past century, including models of sociology, of morality? and, more recently, a model focusing on the idea of addiction as a disease of the brain.

His aims were to give an insight into:

- the direct involvement of the brain in the process of addiction;
- some of the most salient brain structures involved in the process and understanding their natural balance;
- the disruptive systems which lead to addiction; and,
- the way chemical substances used in ChemSex influence the systems.

He stressed that the neurobiology of sexual pleasure can have a perfect connection with the typical drugs used in ChemSex.

He then described some of the major functions of the meso-limbic sytem: to attain pleasure, to reward pleasure seeking behaviours and to store experiences in memory. When the neurotransmitter dopamine gets released into the nucleus accumbens, it creates the sensation of pleasure. Normal reward seeking systems will achieve this reward through work, such as dopamine release after a work out or a run. Addictive drugs provide a shortcut to the brain's reward system by flooding the nucleus accumbens with dopamine. The hippocampus lays down memories of this rapid sense of satisfaction, and the amygdala, which stores sensatory memory, creates a conditioned response to certain stimuli.

Phillipe Batel then explained how the drugs currently used in Chem Sex create chaos with the way the brain stores memory by:

- creating a cognitive process which can be compared to illusions/hallucinations;
- decreasing inhibition (effectively shutting off the areas of the brain controlling the instructions of the meso-limbic system to seek out pleasure) and increasing self-confidence by the illusion of empathy; and
- increasing the time one can perform sexually at the level of high excitement before experiencing the come-down, while at the same time inhibiting the storage of negative experiences, thus creating in effect false memories of perfection, which the participant in ChemSex is not likely to ever match again.

These result in ongoing pleasure-seeking behaviours leading to increased use of drug combinations and the participant being unlikely to achieve his first high again.

As the expectations increase with the stored skewed memories, illusions of the perfect moment, the brain systems change from pleasure seeking to fighting the feeling of a perpetual 'down'. The pleasure associated with an addictive drug or behaviour subsides—and yet the memory of the desired effect, and the need to recreate it, persist.

2. Co-infection linkages

Christoph Boesecke, University of Bonn

Christoph Boesecke outlined linkages between ChemSex and co-infection with a focus on Hepatitis C and HIV. He presented data from 496 questionnaires collected in the context of the PROBE-C Study, where 65% of participants were from Germany, as well as data from an online survey conducted in Berlin with 287 participants and from interviews in the UK on 30 gay men. He also noted that out of 3811 negative MSMs attending sexual health screenings, only 14.8% had been tested for acute HCV, highlighting a missed opportunity to address issues around HCV and ChemSex.

Key points:

- There has been a steady increase in acute hepatitis C infection in Europe among HIV positive people, especially MSMs.
- Fisting and the consumption of nasally administered drugs using the same devices were the strongest risk factors associated with acute Hepatitis C.
- Questionnaires from the PROBE study showed that 12.5% of participants had always or mostly always used condoms, 46% of participants had had sex in a group setting, 21.4% had practiced anal douching with a common douching device. 3.7% reported thinking that none of the men they had sex with in the last 12 months were HIV positive, while 31.3% thought all them were.
- In the Berlin online survey, almost 60% of HIV positive men had had between 11 to 50 partners in the last 12 months compared with 15.4% in HIV negative men; 14% were using crystal meth, with the biggest proportion of users found in HIV positive participants and 2/3 reporting using additional drugs. Over 50% of participants reported sharing snorting devices.
- A study on illicit drug use in sexual settings among 30 gay men in South London showed that slamming was reported by a third of participants with a majority of participants describing overdosing, particularly in relation to GHB/GBL. A third described multiple instances of unintended sexual risk behaviour attributed to drug use; however, a quarter of participants felt in control of their drug use and maintained strict rules about sexual risk management.
- Results from the EMIS study, conducted on 91,477 men from 38 countries showed that unprotected anal intercourse could clearly be linked to the settings of ChemSex for HIV transmission.

3. Underlying psychological issues

Dominic Davies, Pink Therapy

Dominic Davies explored underlying psychosexual issues related to ChemSex and their consequences. He started his presentation by emphasising the importance for people working with gay men of being comfortable talking about sex and that counsellors and psychotherapists generally received no training in this domain.

The Forum learnt that 75% of his patients were actively involved in ChemSex, or had been, and were dealing with the impact and consequences of rebuilding a new life. The majority were high achievers, professionals, most of them were HIV+, some were on PrEP and some were using condoms but not very reliably when high.

Key points:

- Drugs for sex can be fun, with sex being described as more intimate, more intense, more pleasurable and longer lasting.

- Many of the men had underlying performance difficulties and long term or life-long psychosexual problems, which needed to be addressed. For example, treating rapid ejaculation gave people more choices as to how much time they wanted to give to their sex on Chems.
- Many of the men suffered from HIV rejection trauma, underlying a lack of understanding in the community of what being undetectable means.
- Geolocation apps have made drugs and sex easily available 24/7, and apps like Grindr can heighten attachment difficulties.
- ChemSex is also being used in a BDSM context, where issues of consent are extremely important. Men reported getting involved in heavy BDSM as their pain threshold was raised when high, often compounding feelings of shame afterwards.

Recovery programme: Model to be tested

- Smart Recovery approaches using Motivational Interviewing for harm minimisation and recovery
- Nutritional Therapy – Tyrosine & 5 HTP and others
- Urban Tantra Practices, allowing people to relate to each other sexually and safely and building intimacy
- Sensation based play BDSM raising endorphins/dopamine
- Teaching relational intimacy skills & raising self-esteem and body esteem
- Work on shame, minority stress, micro-aggressions
- Building social networks away from the exclusively sex-based one

PLENARY DISCUSSION
Chair: Byan Teixeira
Panellists: Philippe Batel, Christoph Boesecke, Dominic Davies

The panel reflected on the dramatic differences between cities where ChemSex drugs were being used, underlining the complexity of ChemSex and the difficulties in classifying it. While London was a place where being anonymous and finding sex partners was easy due to its size and transient population, ChemSex was also increasing in Finland, despite a small community and more intimate relationships. The way sex was negotiated varied greatly across Europe but other motivations also drove people to ChemSex. Part of the challenge for the community was to understand the variety of motives and find ways to reach out. The panel agreed that we needed to redefine aspirations for the gay community and understand that needs have changed over the years.

Forum participants asked if maybe the hunger for sex was actually hunger for intimacy as Chems can heighten the feeling of intimacy while having sex. This was happening in the context of people often using technology to communicate rather than speaking to each other. The panel stressed that we needed to be clearer on the distinction between being intimate and being physical. Although there is a lot of literature about safer sex and safer drugs, there is less about emotional literacy and little promotional drive about intimacy. This increased use and reliance on technology emphasised the importance of having resources online for people who cannot access services or simply needed information. Applications could also be used to promote access to harm reduction.

The importance of targeted specialist and integrated services was again highly stressed by both the panellists and members of the audience. Frequent screening and immediate treatment of HCV as well as effective referrals to behaviour change support was recommended to avoid HCV re-infection and facilitate elimination. The Forum agreed that we needed to provide the safest environment for people who engage in ChemSex, such as providing clean needles for a start, but we also needed to find ways to support people going through the process of exiting drugs. Some of the community-based responses where gay men can talk together, such as "Let's Talk About Gay Sex and Drugs", were proving to be very useful, and were beginning to be replicated elsewhere, such as in Germany and other UK cities.

EFFECTIVE INTERVENTIONS – THE UK EXPERIENCE

1. Sexual health interventions: prescribing/screening/risk assessments

Joe Phillips 56 Dean Street

Joe Philipps gave an overview of services at 56 Dean Street and highlighted the key components of a successful intervention:

- Risk assessments: questions about sexual partners, status, numbers etc. but also questions about Chem use.
- Testing and treating: Testing for STIs and timely treatment of infections to reduce risk of forward infections; Routine HIV testing and education to help people spot seroconversion; Testing for HCV, including in HIV negative men and non-injecting drug users.
- Promotion of PEP, PrEP support and TasP with education about ARVs and the meaning of an undetectable viral load.
- Simplification of services: extending opening times and weekend opening, quicker services.
- Specialist services where people do not feel judged and where there is time to support people in the best possible way.

2. PrEP and ChemSex: Looking forward

Sheena McCormack Medical Research Council, Clinical Trials Unit, UCL

Sheena McCormack provided an introduction to PrEP (Pre-Exposure Prophylaxis), a drug (commonly known as tenofovir, Tenvir-EM or Truvada) given to HIV negative people as prophylaxis against HIV, taken daily or before, during and after sex. She summarised the results of the 2 most recent PrEP trials in Europe (PROUD and IPERGAY) and explored their significance in terms of HIV diagnoses as well as their potential impact for gay men engaged in ChemSex. The PROUD study randomly assigned HIV negative MSMs to either take Truvada daily straight away or to take it after 12 months; IPERGAY was an event-driven placebo controlled trial where people took pills before, during and after sex.

Key points:

- Both trials achieved an 86% reduction in HIV. 4 cases of transmission occurred (2 in PROUD and 2 in IPERGAY), believed to have happened when participants were not taking their tablets.
- STIs were no more common in those on PrEP and although people on PrEP reported a larger number of partners, it had no impact on the number of STIs.
- In January 2015 in Dean Sreet, 42% of people coming in for PeP reported ChemSex, 26% reported group sex, of which 76% were on Chems at the time.
- Drivers of HIV in PROUD were: a rectal STI and 2 or more partners in the last 3 months, and ChemSex in the last 3 months. 44% reported using chems before taking PrEP and 46% during PrEP, with 14% reporting injecting. Injecting trends seemed to be going up in the latest data.
- Seroconversion has been related to PrEP adherence issues related to ChemSex. In the IPERGAY trial, MSM had been very good at judging the risk and when they needed to take the drug.

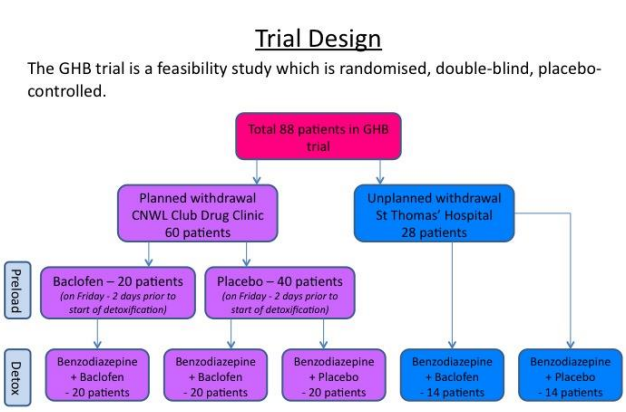
CONCLUSIONS:

- Overwhelming evidence that PrEP adds benefit.
- Overwhelming evidence of need in a sub-population of MSMs.
- Need to better understand ChemSex motivations and behaviours to identify those that need additional support.

3. Psychosocial intervention: care pathways/referrals

Owen Bowden-Jones CNWL Club Drug Clinic

Owen Bowden-Jones talked from the perspective of drug treatment. The Club drug clinic was founded in 2010 to deal with emerging drug trends. The clinic delivers structured drug treatment in the context of a multi-disciplinary service. Around 1000 patients have been treated since its opening, and it became apparent very quickly that MSMs constituted the largest group, coming in mainly because of ChemSex behaviours. Data collected at the clinic indicated that 75% of MSMs seen had never had drug treatment and 50% had injected at least once, with half of them sharing injecting equipment. 60% were HIV positive. In this context, co-location of clinics with sexual health services and sharing of expertise have been two of the critical elements in the response to ChemSex. Issues of cultural competence and harm reduction approaches specific to the drugs used in ChemSex have also been key, as well as linking with other services across London.



The clinic is also about to start a GHB/GBL trial to manage safe G detoxes. The Forum learned that Benzodiazepines, generally used to manage withdrawal symptoms, may be better complimented by the addition of Baclofen. The trial will be randomised, double-blind and placebo controlled, with one group coming in for planned detox and the other made of unplanned emergency patients. Recruitment will start in June.

PLENARY DISCUSSION
Chair: Bryan Teixeira
Panellists:
Joe Phillips 56 Dean Street
Sheena McCormack Medical Research Council Clinical Trials Unit,
Owen Bowden-Jones Club Drug Clinic

The plenary discussion explored some of the differences and convergences between the UK model and European models, with a particular emphasis on PrEP.

Key points:

- STIs are rising across clinics in Europe and PrEP is stopping HIV from rising along with them. We are rising from an historical low and going back to levels from the 70s.
- There was no difference in the use of barrier protection in the PROUD study among PrEP participants and in IPERGAY, participants already had low level of condom use to start with.
- PrEP is not meant to be an answer to STIs, it is just an answer to HIV. We need to devise strategies and policies to screen and treat STIs.
- There is no data on how many people use PEP for PrEP purposes but we know it happens. Many clinics in the UK give information on buying generic PrEP online and provide monitoring support.
- There is a moral barrier in some countries against PrEP rather than an evidence-based approach. Small pilot research projects would enable clinicians and policy makers to be brought on board and have a sense of ownership.
- PrEP is a real opportunity to bring together the whole sexual, HIV, Chemsex package for gay men and we must embrace it and ride on that momentum.
- One of the opportunities around ChemSex is to bring together the expertise in specialist drug services, specialist sexual health services and gay men's community services. None of the services on their own will have the skill-set to deal with this issue.

COMMUNITY MOBILISATION DAY

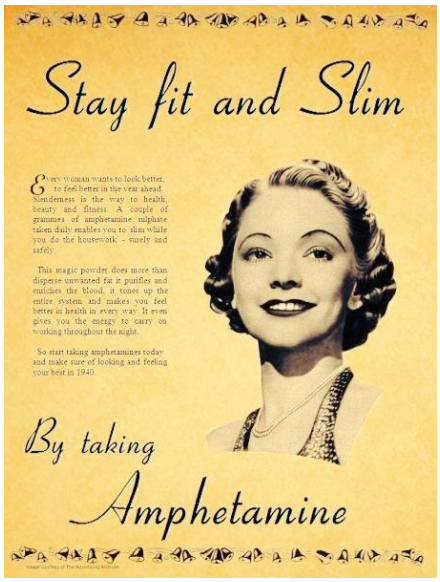
The second day of the Forum focused on the community and services response to ChemSex, and looked towards the future with a brain storming session on future priorities.

PANEL WITH DISCUSSION: PERSONAL JOURNEY OF PEOPLE WHO HAVE ENGAGED IN CHEMSEX
The day started with a panel discussion exploring the personal journeys of three people who had engaged in ChemSex, looking at the contexts of their experiences as well as exploring their motivations and the impact of ChemSex on their lives.

Key points:

- In countries where homosexuality is still considered a taboo and to a certain extent viewed as a disease, MSMs visiting other countries, either for work or for holidays, will seize the opportunity to have sexual encounters and live their sexuality freely while abroad. They often won't care if chems are involved or not. Research in Armenia showed that MSMs had indeed engaged in ChemSex and also had unprotected sex under Chems while abroad. Further research will be needed to see if this type of sex tourism will affect the rates of HIV infection in the MSM population in their countries of origin.

- Although ChemSex is usually associated with gay men, there are also other populations who regularly use drugs for sex; among them are lesbians engaged in a more hardcore club scene, Trans* people or heterosexual women who take the drugs/enjoy sex with their gay/bisexual male friends. When these encounters expose non-MSM to higher-risk sex with people from high HIV/STI prevalence populations, or where appropriate support might not exist in traditional drug services, it could be defined as ChemSex. It was also noted that sexuality and sexual boundaries could become very blurred under the influence of drugs.
- While we think of ChemSex as a recent phenomenon, amphetamines have been around for a long time. Advertisements from 1942 show them being advertised as slimming aids, while a version of crystal meth called Permitin, sold as an energy pill, was freely available until 1984. The Second World War was a war fought with drugs: in Germany, 34 millions doses of Pervitin were produced per month. It is worth pointing out that every drug was legal at some point. Alcohol is still the biggest drug of all, with 74000 fatalities per year in Germany, compared to 944 due to illegal drugs.



- STIs are seen as a big problem today but looking at history, they have simply returned to 1970s levels and it's likely they were underreported at the time. It really looks like a return to baseline, as people are less afraid of having sex. However, 90% of syphilis infections occur in gay men. This is a very large number considering they only represent around 5% of the population. Resistance to STIs is increasing so there is a need for caution but it is quite likely treatment of STIs will eventually need to change to combination therapy.
- Experiences of ChemSex and of what people think of ChemSex are extremely varied, a point that makes the work of professionals very complex and at times difficult. A great number of people are managing and controlling their drug use, a fact that must not be forgotten when talking about ChemSex.

CONSENT AND RESPONSIBILITY – A UK PERSPECTIVE
Catherine Bewley Galop
Monty Moncrieff London Friend
This session explored issues of consent and responsibility within a ChemSex context, starting with an overview of UK laws relating to sex and sexual assault, with a particular emphasis on the 2003 Sexual Offences Act. The session also examined consent challenges and criminal justice issues as well as identifying appropriate community responses.

Catherine Bewley and **Monty Moncrieff** began their presentation by introducing the work of Galop, an LGBT anti-violence organisation started in 1982 as a community response against police entrapment, and that of London Friend, the LGBT organisation running Antidote, the UK's only LGBT drug and alcohol service. Antidote was the first UK service to identify ChemSex trends and works in close partnership with the NHS, including developing ChemSex clinics in GUM services.

Catherine Bewley gave an overview of the UK context of consent, explaining that the collective memory about policing around sex was creating barriers to people speaking up and accessing justice. Gay men in particular feared they would not be taken seriously and might face a moralistic response or exposure, coupled with a real threat of being charged with drug offences. She summarised the 2003 Sexual Offences Act, which sets out terms relat-

ing to the freedom to consent, the capacity to consent, and how consent represents a moment in time, a key concept in a ChemSex context, as it underlines how consenting to a specific act at a specific time does not imply continuous consent.

Monty Moncrieff followed on by explaining how the law could be challenging in a ChemSex context. The effects of the drugs themselves, leading to clients reporting a loss of awareness, as well as the "in the moment" sexual drive resulting from taking them, could blur issues around consent. It was also noted that being at a sex party did not imply ongoing consent with all present. The lack of clarity about what consent means can lead to behaviours liable to prosecution, even if unintended. Unfortunately, there have also been reports of deliberate actions involving assaults as well as other crimes.

Both speakers emphasized the need for the community to take the lead and name what was happening, and while validating entitlement and pleasure, named harm where it happened. The response needed to be collective.

KEY AGENDA MOVING FORWARD:

- The community needs to have the courage to name issues of rape, sexual assaults and talk about them openly.
- The community needs to take the lead and not let the press and others define the agenda around issues of consent and ChemSex in general.
- Men engaged in ChemSex need good information to help them make informed choices.
- The community needs to be actively involved in criminal justice issues to ensure a fair informed response.

BEHAVIOUR CHANGE AND COUNSELLING SERVICES FOR CHEMSEX: THE TWO STAGES OF PSYCHOSOCIAL INTERVENTION

1. Early Intervention considerations

Jamie Willis Antidote @ London Friend

Jamie Willis highlighted the typically different profile of people seeking treatment for sexualised drug use compared to traditional drug services: clients were mostly high functioning, less likely to have a criminal record and tended to respond well to interventions. Shockingly, they had very little knowledge about the drugs themselves and about harm reduction strategies. As a result, the majority of Antidote's clients did not feel comfortable accessing mainstream treatment and interventions needed to be culturally adapted and healthcare-based. Sexual health and drug use basically had to be tackled together as they no longer existed in silos. Triggers to seeking support included arrest and negative experience.

At this early stage of intervention, Jamie emphasized the importance of building on motivation to seek help, by helping people to define their own problematic use and rate both the positive and the negative aspects of their ChemSex experience. He also recommended as part of an early intervention, the use of a G monitor sheet, preferably given to someone agreeing to stay sober, where the doses and times could be recorded for each participant attending a sex party.
In terms of assessment considerations, asking questions about knowledge on drugs and harms, on injecting practices, on sexual risk behaviours, alcohol consumption and on issues around consent were essential in order to devise a successful individualised intervention.

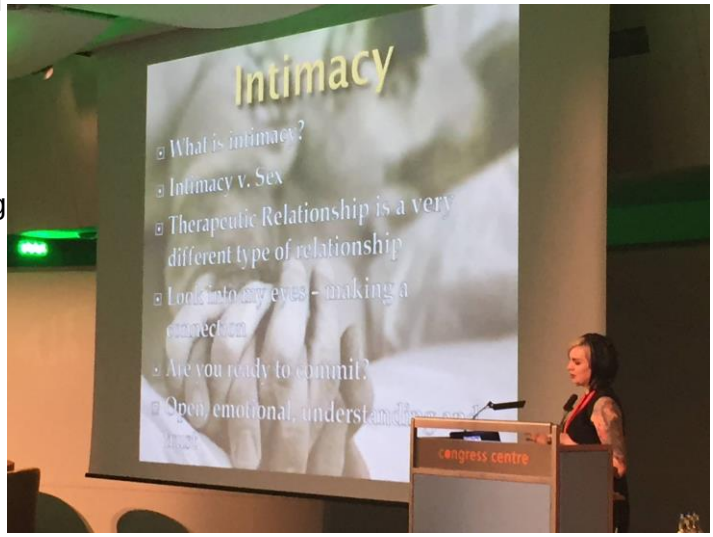
The second stage of intervention concentrated on strengthening commitment. At that point, it could not be assumed that someone would be working towards abstinence; it could just

be around harm reduction. In terms of what works, brief interventions in community and healthcare settings, good app hygiene, informal support, structured sessions and group key work have good evidence-based results. Empowerment and involvement of clients and their “significant others” and creative engagement of support networks are also essential as well as education programmes and recovery oriented services with a focus on strength and hope.

Jamie Willis concluded his presentation by highlighting the work of SWAP, an intensive 4 weeks structured programme designed specifically to support clients to address issues around club drug use, which has been very successful and had led to the creation of a peer support group.

2. ChemSex and therapy

Katie Evans After Party Service



Katie Evans explored some of the recurring issues in her therapy sessions with clients coming in with ChemSex related problems. She drew attention to the importance of intimacy and the way it was often perceived as being the same as sex by her clients, a perception often due to the feelings of empathy experienced under the influence of drugs. She noted that a therapeutic relationship in itself could foster a new way of developing deeper connections by committing to open up, to trust someone and to develop a connection.

She emphasised the importance of developing one’s emotional vocabulary, by learning to name emotions and express experiences and feelings, thus allowing for emotional growth and helping to burst the drug bubble protecting the individual from the outside world.

She explored how the focus on the external, where one is dependent on the judgement and validation of others to feel good and valued, needed to be shifted to the internal and the understanding of one’s own worth. Part of the process was to explore issues of identity to discover the self away from sex and drugs, and find an internal space where one could get acceptance of oneself and learn to work through internalised homophobia or issues of bullying. She concluded by stating that the overall objective was to help her clients to learn to love and respect themselves so they would treat themselves as they would treat something they cherished.

PLENARY DISCUSSION
Chair: Bryan Teixeira
Panellists:
Catherine Bewley Galop
Monty Moncrieff London Friend
Jamie Willis Antidote
Katie Evans After Party Service

During the discussion, panellists and the audience reiterated and elaborated on several of the key issues that had been raised. There was a consensus that while self-esteem had come up a lot, the change in social places, the economic situation and the disappearance of LGBT safe spaces all played their parts. Some people went to sex-parties to escape and meet their very basic needs, which was of particular concern for young people. The panel agreed that while we should not lose sight of people engaging in ChemSex and having a great time, there was a darker side, which could not be ignored. There was an important narrative to be told about how drugs had developed and how community attitudes had changed.

Several panellists reiterated their worries on the issue of consent and emphasised the need to find ways to address this situation in the ChemSex setting. The starting point of the conversation should be around speaking up about difficult and dangerous things and build some kind of community cohesion around taking responsibility. A question taken from the floor highlighted the need for training of health professionals around this issue, as patients were often not taken seriously and many people left the hospital without saying anything. Many sexual health professionals were not comfortable speaking about topics such as sexual assault. People need honest and practical advice and information and services need to take the initiative to ask questions around ChemSex and allow people to speak freely and without worries. This might facilitate intervention before crisis point when people were accessing drug services. The panel agreed that the Forum had opened up the discussion.

There was a clear articulation of the importance of individual and community participation to shift community norms and of the need for advocacy services and safe spaces. All agreed that joint working and partnerships were key to developing effective ChemSex responses.

COMMUNITY (NON-CLINICAL RESPONSES)
Policy, messaging, safe spaces, well-being etc
Michelle Thornber-Dunwell
Cliff Joannou Attitude Magazine
Yusef Azad National AIDS Trust
Peter Darney Writer/Director 5 Guys Chillin
Ben Collins IHP and ReShape
Chaired by **David Stuart**

This discussion started with a presentation from **Yusef Azad** on the UK community policy response to ChemSex. He began by stating that policy should not just be left to the politicians or to the health professionals. People from across all sectors needed to be brought together into the discussion, with particular emphasis on the people responsible for the financing and planning of health services, as they needed to understand what was actually going on and be pressed to issue best practice guidance and ensure it would be used and implemented to see real service improvement.

He explored what the policy issues were, such as inconsistent practice around screening for ChemSex, limited access to specialised services for MSMs and, in the case of the UK, a mismatch between open access sexual health services and locality-based drug services. He also highlighted the assumption in commissioning services that training members of staff in non-discrimination of LGBT sexual identity was the same as training around sexuality. There is still a great challenge around the competence of generic services to meet the need of MSMs. He stated that solutions and services needed to be convincing as cost effective and indeed cost saving to society and to the public purse. Amongst some of the possible solutions to policy issues, he cited:

- Use of an agreed screening tool in sexual health services for drug use.
- Ongoing training of both sexual health and drug service staff.
- Cross-boundary services which reflect MSMs life and preferences.
- Improvement in data collection on need, interventions and outcomes.

During the following discussion several pivotal elements related to the session topics were broadly addressed. **Cliff Joannou** spoke about the reluctance of the gay media and gay businesses to talk about ChemSex, stating the difficulty of wanting on one end to represent the best of the gay scene and promoting it and, on the other end, talking about issues affecting the same scene. He stated than when G came onto the scene and the clubs started to close because of drug issues, the drive to sort this out started to develop, highlighting the split between running a business and having a social responsibility. Cliff also spoke about his work to address LGB&T-inclusive relationship and sex education in schools, and how this might improve ChemSex prevalence amongst future generations.

Michelle Thornber-Dunwell, known as **"**the mother of Vauxhall" for her longstanding work helping young gay men on drugs with nowhere else to go, agreed that ChemSex had been a difficult word to adopt. Medical professionals did not know about these drugs, the gay scene ignored the issue and young people were getting ill and looking for support. She knew that these things were happening and wanted to raise awareness in the clinical community, especially counsellors. It quickly became apparent that the only way to get the point across was to get it into a medical journal so she and co-author Tony Kirby published an article in the Lancet. It was the most read article of this particular issue, and the first time the word "ChemSex" had been referenced in a medical journal. Since then, many articles have been published.

Peter Darney, writer/director of "5 Guys Chillin'", a West End play about ChemSex commented that issues relating to ChemSex often go back years and years. Most of the articles do not talk about the reasons people were in these situations. Gay people often grow up invisible, with no guidance on sex education, intimacy, respect and relationships. Sex education had not been updated for years, there is no policy on sex education and relationship inclusive of LGBTs. Sexuality is suppressed and young people end up going online, go onto apps. The next thing you know their first sexual encounter is ChemSex. The consequences

of a politics of Austerity and associated social issues also come into play. There is a huge amount of interlocking issues, self-stigma, self-defeat and not much of a sense of community.

Ben Collins agreed that the community was much more fragmented, with far less face-to-face communication. We needed to move the story from the scandal of ChemSex to the scandal of our failure to respond to it. ChemSex work cannot be done without the community and it's important for people to realise that the community can be anybody; they do not have to create huge projects. New formations were being created and issues of safe places were talked about a lot more. An audience member pointed out that responsibility was being brought back to the community with events like Let's talk about gay sex and drugs. As well as a need for a place to talk, there is also a huge need for information, and businesses could pay a part in this, especially sex on premises venues. Some clubs refuse to store clean needles, as it would acknowledge that drug taking is taking place, however, in the long run a business wants to be associated with a credible brand, so having a credible harm-reduction strategy would be beneficial to them as well.

NEXT STEPS

The final session of the meeting was dedicated to formulating a few key conclusions and exploring the next priorities and next steps for action.

KEY FINDINGS:

- In the past 5 years there has been a migration to newer drugs with an increasing trend in injection. Although more prevalent in the UK, sexual drug use is rising steadily across Europe. The lower prevalence in Eastern Europe is probably due to lack of opportunities but data shows sex tourism, which includes MSMs from Eastern Europe, as one of the drivers of ChemSex.
- The facilitators of ChemSex are technological, structural, psychological and epidemiological.
- The drugs currently used in ChemSex decrease inhibition and create a cognitive process inhibiting the storage of negative experiences and creating false memories of perfection. This leads to pleasure seeking behaviours with an increased use of drugs and a feeling of perpetual down when failing to match these early memories.
- ChemSex participation tends to accelerate after an HIV diagnosis. MSMs engaged in ChemSex are also more likely to report unprotected anal sex and to have higher rates of STIs and HCV. Frequent screenings and immediate treatment as well as access to PrEP are effective interventions to prevent onward infection, as are tailored psychosocial support and community cohesion. Unfortunately, at present France is the only European country with a PrEP programme. Meanwhile, MSMs access PrEP through PEP prescriptions or by buying generics online.
- MSMs engaging in ChemSex tend to be well-educated and high achievers with little or no knowledge of drugs and harm-reduction strategies. There is an acute need for safe injection advice as well as general information about safer drug use.
- MSMs engaging in ChemSex do not perceive themselves to be abusing or misusing drugs, nor do they identify as drug addicts; they are less likely to access mainstream drug services. Specialist and integrated services, where they feel more comfortable speaking about their sexuality and/or their drug use, are key to encourage them to access services and seek support.

- ChemSex can have a significant impact on both mental health, often exacerbating existing underlying psychological issues, and physical health. A multidisciplinary approach integrating mental health, sexual health, HIV and drug services and testing combined with community initiatives, is the foundation of an effective holistic wellbeing programme able to respond to the needs of this particular community.
- There is a lack of clarity about what consent means and there have been reports of rapes and sexual assaults. Men engaged in ChemSex need good information to help them make informed choices and the community needs to take the lead to tackle these issues. The criminalisation of drugs has created barriers in terms of reporting sexual abuse under the influence of drugs and also barriers to honesty while talking with health services.

KEY AGENDA MOVING FORWARD

- Better coordination across Europe, with a common platform, joint action and cross-country adaptation of existing successful interventions.
- Development of a political strategy for the future and a better articulation of the cost of not addressing ChemSex. Responses to emerging growing needs in the context of cuts must be made by offering services and solutions that can be seen as cost-efficient and even cost-saving.
- Development of quality standards: The pressure in sexual services is acute and will continue growing; we need to ensure resources go further and are prioritised. How do we measure effective interventions? What do we think is effective? What are the challenges?
- Data gathering: There are still gaps in data and coherent evidence-based data is important to get services commissioned. The dissemination of the pre-conference online survey results across Europe can be a helpful step towards data gathering.
- Development of common definitions around ChemSex and addiction, facilitating a unified response.
- Implementation of a series of trainings for European professionals in advance of the next forum to become culturally competent and have better engagement with their patients.
- Development of a network or platform centred around ChemSex where people can easily reach counsellors, psychotherapists, get information etc.
- Focus on solutions: Do people who manage their ChemSex habit well have skills that could be shared? Could the BDSM community help us with their experience around issues of consent, risks management etc.?
- Identify strategies to facilitate social participation, community involvement, safe places and mobilisation.

ANNEXE

PROGRAMME

Training Day
Wednesday 6 April, 10.00 – 16.00

09.30 **Registration at Congress Centre**

10:00 **Introduction to the day, housekeeping**
Bernard Kelly, Courtyard Clinic, St Georges University Hospital, UK

10:15 **The ChemSex 'phenomenon'**
Monty Moncrieff, London Friend, UK

11:00 **Introduction to the global prevalence of ChemSex**
David Stuart, 56 Dean Street, UK

11:45 **Injecting use of "chems**
Roy Jones, Turning Point, UK

12:15 **Outreach and community engagement**
Tadgh Crozier, AfterParty, UK

12:45 **Lunch**

13:30 **A brief introduction to Motivational Interviewing**
Bernard Kelly

15:30 **Summary of day**
Bernard Kelly

16:00 **Closing**

18.30 **Forum Opening Night: The ChemSex Monologues**
A series of short dramatic monologues reflecting different characters involved with the ChemSex scene.
Written by playwright Patrick Cash (*The Clinic*, *Queers*)
Directed by Luke Davies
Featuring a cast of talented local London performers

Throughout the Forum Days, please visit the Visuals and Relaxation Rooms in the Congress Suites -1 level for:

Videos:
- G O'clock, Mitchell Marion, UK
- Let's Talk About Gay Sex and Drugs, Leon Lopez, UK
- Let's Talk About Gay Sex and Drugs, documentary short by VICE
- 11 ChemSex harm reduction films by 56 Dean Street and Alejandro Medina, UK

Photography:
ChemSex photography, Matt Spike, UK

Data / Evidence Day
Thursday 7 April, 10.00 to 17.30

Morning

09.00 **Registration and poster review**
Congress Centre

10.00 **Welcome**
Bryan Teixeira, Meeting Chair, France
James Beckett, Chelsea and Westminster General Manager for HIV / GUM, Pathology and Dermatology and 56 Dean Street, UK
Matthew Hodson, GMFA, UK
Ben Collins, International HIV Partnerships and ReShape, UK

10.30 **The ChemSex challenge: Overview of London / UK experience**
David Stuart, Forum Chair, 56 Dean Street, UK

11.00 **Towards a ChemSex map: Overview of data and evidence**
Adam Bourne, London School of Hygiene and Tropical Medicine, UK

11.30 ***BREAK***

12.00 **ChemSex across Europe: What's known and what's not?**
Axel J. Schmidt, London School of Hygiene and Tropical Medicine, UK; Swiss Federal Office of Public Health, Switzerland
Niels Graf and Anna Dichtl, Frankfurt University of Applied Sciences, Germany

12.45 **Plenary discussion with opening speakers and panellists**
Chair: Bryan Teixeira

13.15 ***LUNCH and poster review***

Afternoon

14.00 **"Oh those boys…": An historical perspective on sex and drugs in gay men's lives**
Leon Knoops, Mainline, The Netherlands;
Bernard Kelly, Courtyard Clinic, St Georges University Hospital, UK

14.30 **Clinical perspectives**:
1. The brain and addiction
Phillipe Batel, Clinique Montevideo, France
2. Co-infection linkages
Christoph Boesecke, University of Bonn, Germany
3. Underlying psychosexual issues
Dominic Davies, Pink Therapy, UK

15.15 **Plenary discussion with previous panellists**
Chair: Bryan Teixeira

15.45 ***BREAK***

16.00 **Effective interventions – the UK experience**:
1. Sexual health interventions: prescribing / screening / risk assessments

Joe Phillips, 56 Dean Street, UK
2. PrEP and ChemSex: Looking forward…
Sheena McCormack, Medical Research Council Clinical Trials Unit at UCL and 56 Dean Street Sexual Health Clinic, UK
3. Psychosocial intervention: care pathways / referrals
Owen Bowden-Jones CNWL Club Drug Clinic, UK

16.45 **Plenary discussion with previous panellists**
Chair: David Stuart

17.15 **Summary of the Day**
Chair: Bryan Teixeira

17.30 ***BREAK***

18.30 **Let's Talk About Gay Sex and Drugs**
A London community response to ChemSex
Hosted by Patrick Cash, Chelsea and Westminster Hospital and 56 Dean Street
Basement Ku Bar
30 Lisle St, London WC2H 7BA

Community Mobilisation Day
Friday 8 April, 10.00 to 17.00

Morning

09.00 **Registration and poster review**
Congress Centre

10.00 **Welcome to a different kind of day**
Bryan Teixeira and David Stuart

10.15 **Panel with discussion: Personal journeys of people who engage in ChemSex**
Artyom Hovhannisyan, Armenia
Siegfried Schwarze, Projekt Information, EATG, Germany
Silvia Ferrari, 56 Dean Street, UK

PLEASE NO PHOTOGRAHY DURING THIS SESSION

10.50 **Consent and Responsibility – a UK perspective**
Catherine Bewley, Galop, UK
Monty Moncrieff, London Friend, UK

11.20 ***BREAK***

11.45 **Behaviour change and counselling services for ChemSex: The two stages of psychosocial intervention**
1. Early intervention considerations
Jamie Willis, Antidote@London Friend, UK
2. ChemSex and therapy
Katie Evans, AfterParty, UK

12.30 **Plenary discussion with previous panellists**
Chair: Bryan Teixeira

13.00 ***LUNCH and poster review***

Afternoon

14.00 **Community (non-clinical) responses discussion**
Policy, messaging, safe spaces, well-being, etc.
Michelle Thornber-Dunwell, UK
Cliff Joannou, Attitude Magazine, UK
Yusef Azad, National AIDS Trust, UK
Peter Darney, writer / director "5 Guys Chillin'", UK
Ben Collins, IHP and ReShape, UK
Chair: David Stuart

15.30 ***BREAK***

15.45 **Next steps after the Forum**
Developing a network; identifying key resources and future research priorities; links to maintain communication

Open discussion with David Stuart, Matthew Hodson and Ben Collins
Facilitated by Bryan Teixeira

16.15 **Priorities for a future Forum**

Open discussion with David Stuart and Adam Bourne
Facilitated by Bryan Teixeira

16.45 **Summary of the Day**
Bryan Teixeira

17.00 **Break**

19.00 **Showing of *ChemSex*, a documentary film by VICE**
Congress Centre

After-film panel discussion: The impacts of ChemSex on our communities
David Stuart
Matt Spike, ChemSex photography exhibitor, and protagonist in ChemSex documentary, UK
Mitchell Marion, director, G O'clock, UK
Leon Lopez, director, Let's Talk About Gay Sex and Drugs

European ChemSex Forum

6-8 April 2016 Congress Centre, London

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