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Editorial

Sharing solutions for a reasoned and evidence-based response: chemsex/party and play among gay and bisexual men

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Abstract. This Special Issue of *Sexual Health* examines research and healthcare practice relating to sexualised drug use among gay, bisexual and other men who have sex with men (GBMSM), colloquially known as 'chemsex' or 'party and play' (PnP). It draws together evidence relating to the epidemiology, sociology and psychology of chemsex, as well as the policy, community and clinical interventions that are required to ensure men have access to high-quality health care that meets their needs and reduces harm. Findings and discussions within the Issue emphasise the need to sensitively, non-judgementally and meaningfully engage with gay men about their engagement in chemsex in order to help improve their sexual health and wider wellbeing.

Additional keywords: drug use, gay men, men who have sex with men, risk behaviours, sexually transmissible infections.

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This Special Issue of *Sexual Health* examines research and healthcare practice relating to sexualised drug use among gay, bisexual and other men who have sex with men (GBMSM), colloquially known as 'chemsex' or 'party and play' (PnP). This phenomenon has attracted media and political attention across the world, with concerns also expressed by health professionals for the transmission of HIV or other sexually transmissible infections (STIs). Previous research has identified how using drugs during sex can facilitate environments in which HIV and other STI transmission is more likely to occur,[1] and has outlined a variety of physical and mental health harms that men are exposed to.[2] Hyperbolic news reporting has often painted a picture of chemsex as being ubiquitous, always risky and always out of control. While there are indeed some who have struggled to manage their use of drugs in sexual settings, the legal status of the drugs used and such reporting (which demonises these men) can increase perceived stigma, creating a barrier to safe and honest disclosure to health professionals, friends and families.

Using drugs in a sexual setting is not new and has been documented with other populations and with a variety of substances over the decades.[3] What is different about this context is how the drugs most commonly utilised today facilitate a more intense sexual session, greater longevity of sex and, with it, the potential for a higher number of sexual partners and likelihood for condomless sex. Chemsex in a Western European context typically includes the use of mephedrone, gamma-hydroxybutyrate/gamma-butyrolactone (GHB/GBL), crystal methamphetamine or ketamine,[1] often taken in a variety of polydrug-use combinations. In Australian, South-East Asian and North American contexts, mephedrone use appears rare, and use of GHB remains at low levels at present.[4,5] Such differing patterns of use reinforce the need for both local drug monitoring and for harm reduction and sexual health interventions to be tailored to the trends of the local population.

Many clinicians used to working to a medical model of diagnosis and treatment in sexual health can find the disclosure of problematic sexualised drug use a challenge to manage. In seeking to better understand and respond to the issue, this Special Issue is deliberately multidisciplinary in nature. Chemsex is a behaviour, influenced by psychological factors (such as using drugs to overcome sexual anxieties), social forces (such as how normative drug use among gay men is perceived to be) and cultural developments (such as the way in which sex between men is facilitated by digital technologies or sex-on-premises venues). Hickson (in this Issue) encourages the reader to examine "the relationship of the rise of chemsex to

the broader features of both contemporary gay lives and the societies in which they are lived".[6] Recognising when personal drug use is becoming problematic can be challenging, but can be influenced by community-level interventions and by health and social care professionals asking the right questions about drug use in the most non-judgemental way. Overcoming a problematic relationship with drugs and sex or avoiding harm requires evidence, expertise and access to a variety of professional services. This Special Issue draws together evidence relating to the epidemiology, sociology and psychology of chemsex, as well as the policy, community and clinical interventions that are required to ensure men have access to high-quality health care that reduces harm.

In relation to the epidemiology of chemsex/Party and Play, all quantitative data sources in this Special Issue[5,7–9] point to the fact that the absolute proportion of men engaging in chemsex is low. Contrary to some media reporting on the topic, only a minority of GBMSM use drugs, and only a small proportion of these do so in a sexual setting. Frankis *et al.* document a low prevalence of chemsex in their four-country study, but highlight significantly higher rates of use among men from certain demographic groups.[9] HIV-positive GBMSM, for example, had four-fold the odds of using drugs associated with chemsex, while those who had been paid money or goods in exchange for sex have 4.7-fold the odds.[9] However, Graf *et al.* remind us that we should not make the assumption that all chemsex is problematic, and indeed describe participants who carefully manage their drug use and have experienced little harm or sexual ill-health.[7]

This is, of course, not always the case, and O'Reilly provides a valuable clinical case study of a HIV-positive man engaging in chemsex.[10] His paper illustrates the potential for rapid escalation of drug use and also challenges in men recognising when their own use becomes problematic (despite consuming very large amounts of drugs and having frequent STIs). In a similar vein, Smith and Tasker provide a rich account of the psychological impact that chemsex can have on some gay men.[11] Crucially, they highlight the challenges in establishing or maintaining a sex life without drugs and several of their participants describe feeling out of control or socially isolated. Hammoud *et al.* comprehensively document the social characteristics of men who use GHB, and while a lesser proportion used the drug in Australia than is observed in other countries, significant harms are associated with its use.[5] More than half (50.5%) of men who had used GHB regularly within the previous 6 months reported an overdose at least once.[5] Following reports from the UK of a significant rise in GHB-related deaths,[12] it is crucial that countries where GHB is only just becoming established are primed to meet the harm-reduction need.

Even in this context, it is important that we understand and acknowledge the psychological motivations for sexualised drug use, and the social factors that drive or maintain it. Graf *et al.* point to the very real, tangible and positive benefits of using drugs during sex, particularly in lubricating social contact and increasing self-confidence around sexual partners.[7] This notion of connection to others is reinforced by Power *et al.* in their survey of GBMSM living with diagnosed HIV in Australia.[8] They identified that men using drugs associated with chemsex were more likely to report spending time with other people living with HIV or other lesbian, gay, bisexual and transgender (LGBT) people than with men who did not use such drugs. Such connectivity helps to explain the higher levels of resilience and lower levels of perceived HIV-related stigma observed among those engaging in chemsex compared with those who do not.[8] Hammoud *et al.* also identified that men using GHB were strongly connected to networks of other drug-using gay men, which highlights a clear role for community-based interventions that challenge norms around drug use, disseminate sexual health-related information and provide harm-reduction information or skills.[5]

Indeed, the diversity of community- and clinic-based responses to chemsex/Party and Play comprise a significant proportion of this Special Issue. All of the community-based contributors (Bakker *et al.*[13], Hugo *et al.*[14], Burgess *et al.*[15], Stardust *et al.*[16]) emphasise the importance of multi-pronged approaches, including: direct contact interventions with men engaging in chemsex (e.g. psychotherapeutic support/counselling), health promotion and education (such as websites seeking to inform sexually adventurous men) and a general sex-positive, harm-minimisation approach to engage GBMSM in non-judgmental discussion about chemsex. Goyette *et al.* provide a tool for supporting clinical decision-making around substance use in sexual health settings and, in doing so, provide a template for initiating discussion with patients on this topic in a sensitive manner.[17]

Both Moncrieff and Stevens and Forrest examine the policy environment relating to chemsex.[18,19] Given that this phenomenon relates to sexual health, drug use and HIV, it has proven easy to fall between the cracks of service provision as different sections of the health and social care system consider it another's responsibility to address. Stevens and Forrest explore the various international policy mechanisms that state-level actors can utilise in advancing health care and human rights for men engaging in chemsex (including the Sustainable Development Goals, the UNAIDS 90:90:90 framework and the policies of the United Nations Office on Drugs and Crime).[19] They also emphasise the need for advocacy to positively influence the position internationally in relation to harm reduction and service access for gay, bisexual and other men who have sex with men. In his position, as the head of an LGBTI organisation that was first to provide support to men engaging in chemsex in England, Moncrieff provides a case study of how necessary policy and service change was achieved.[18] This 10-year process necessitated the involvement of numerous state actors and agencies, but has resulted in an improved (if still imperfect) environment of supportive health and community sector interventions to improve the wellbeing of this population. Taken together, these two policy-related articles may prove to be a valuable resource for those lobbying to effect change that enables appropriate chemsex health care in their own jurisdictions.

It is our hope that this Special Issue helps us to move on from hysteria or demonising discourse that has been associated with this topic, and instead focus attention on those sections of the GBMSM population who are most in need of high-quality sexual health or drug services. The authors and organisations included represent some of the early interveners in the lives of

gay men in relation to sexualised drug use. There is much to be learned here about how to sensitively, non-judgementally and meaningfully engage with gay men on this topic to help reduce the harms they are exposed to and, in doing so, improve their sexual health and wider wellbeing.

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