CONNECTION, CARE, COMMUNITY:

Strengthening Harm Reduction for GBT2Q People who Use Drugs in Canada

SUMMARY REPORT

HIV LEGAL NETWORK

RÉSEAU JURIDIQUE VIH

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INTRODUCTION

The use of both legal and criminalized substances plays a significant role in the lives of many gay, bisexual, trans and/or queer men, and other men who have sex with men, as well as Two-Spirit and non-binary people ("GBT2Q people"). This role can be both positive and negative. There is ample evidence that, for various reasons, GBT2Q people have higher rates of substance use, including problematic use. Similarly, at the population level, the types and patterns of drug use are different for GBT2Q people than for the population as a whole, and many GBT2Q people have particular relationships with substances and patterns of use that are intertwined with social and sexual identities, networks, and behaviours. This has implications for reducing the harms sometimes associated with substance use, and preventing and treating problematic use, among GBT2Q people.

In Canada, gay, bisexual, and other men who have sex with men (GBMSM) have long been, and remain, the single largest "key population" represented among people living with HIV, and people who inject drugs (and who are not identified as GBMSM) represent the third largest.[1] As a population, men who both have sex with men and use drugs face heightened risk of HIV, hepatitis C virus (HCV), and other sexually transmitted or bloodborne infections (STBBIs),[2] as well as other harms sometimes associated with substance use. Meanwhile, both GBT2Q people and people who use drugs face barriers to healthcare, including harm reduction services and services for preventing and treating problematic substance use. The intersection of these two identities means that GBT2Q people who use drugs have particular needs and face additional barriers. Differences in relation to HIV status, gender identity, Indigeneity, race, ethnicity, age, ability, level of education, socio-economic status, involvement in sex work, current or previous incarceration, and more play a role in shaping one's sexual identity and behaviour, use of substances, and access to health and other services.

Despite this, until recently there has been limited research into the health needs of GBT2Q people who use drugs. Less than a decade ago, Rainbow Health Ontario and the Canadian Harm Reduction Network jointly observed that "Canadian data is solely lacking on 2SLGBTQ+ substance use, associated risks, and harm reduction."[3] Encouragingly, there has been a significant increase over the past decade in research into drug use among GBT2Q people and related health concerns, and important initiatives to create information and services. Much of the research that does exist is driven by a concern about HIV and other STBBIs, particularly among GBMSM who use drugs. In particular, the topic of sexualized drug use — including the sub-category known as "chemsex" or "party and play" (PnP) — has attracted attention. More data and discussion has helped spur new initiatives and programs to address problematic chemsex. But the response is still in its early stages. There are still many gaps in the research, relatively few programs specifically for this population, and ongoing barriers to the services that do exist. Equitable access to needed programs — both for the prevention of HIV and other STBBIs specifically and for the protection and promotion of health more generally — is a matter of ongoing public health and human rights concern.

There has been even less attention to the need for action at the level of public policy as part of protecting and promoting the health and human rights of GBT2Q people who use drugs. To the extent that this has been considered, it has been largely in the context of HIV-related advocacy, where the links between advocating for

the rights of LGBTQ+ people and the rights of people who use drugs, particularly based on a concern for health, are well understood. But the health and other human rights of LGBTQ+ people who use drugs should also be a consideration more broadly, beyond just HIV, within both drug policy and LGBTQ+ rights movements. There have been important instances where these connections have been made,[4] including in the Canadian context.[5] But these have been relatively few and far between. For various reasons, including the stigma and prejudice still surrounding both gay sex and drug use — and particularly the combination of the two — there has been reticence in some quarters to take up the health of GBT2Q people who use drugs as an important human rights issue.[6]

> *Both the LGBTQ+ liberation and drug policy reform movements are rooted in the principles of privacy, personal and bodily autonomy, and the need to tackle stigma, moral panic, police surveillance and repression.* [7]
>
> — HIV Legal Network, Submission to Parliamentary committee, 2019

OBJECTIVE, OUTPUTS, SCOPE, AND APPROACH OF THIS PROJECT

This project seeks to identify what can and needs to be done to strengthen the response to HIV, other STBBIs, and other health concerns among GBT2Q people who use drugs, including in the areas of legal and policy measures, funding, research, education and training, service provision, and community spaces. To that end, the HIV Legal Network is producing the following resources:

- This **Summary Report** draws on three sources: an extensive literature review; interviews with selected key informants, most of whom are GBT2Q people who use(d) drugs and all of whom are involved in providing services and/or community organizing related to harm reduction; and an environmental scan of programs and initiatives in Canada relevant to substance use by GBT2Q people.

- An **Agenda for Action** sets out recommendations for action in various areas, informed by and complementing this summary report.

Scope and methods of literature review

This document contains a heavily abridged summary of the most salient literature regarding substance use, and harm reduction and treatment needs and interventions, among GBT2Q people. Selected references are cited.

The exercise was not conducted as a systematic review of literature indexed in multiple databases. Instead, it was an iterative process that included:

- searches via Google Scholar using a variety of search terms for articles related to substance use among 2SLGBTQ+ people (with a focus on GBT2Q people);
- searches in selected journals identified as important and likely sources of relevant articles, based on their subject matter focus (e.g. substance use, drug policy, 2SLGBTQ+ health, HIV and sexual health), prominence in the field, and observed history of publishing relevant articles;
- reviewing reference lists in the peer-reviewed literature and reports in the grey literature to identify other items of potential relevance;
- webinars and recordings of select conference presentations available online;
- consultation with particular experts in specific fields (including the key informants interviewed) about any documents they consider key;
- review of a partial draft of the literature review from three independent, external reviewers who are all academic researchers with years of expertise in this field;
- searching websites of civil society organizations and government departments of relevance; and
- contacting some organizations directly with inquiries.

There is potential bias in that the review of literature was conducted primarily in English, although French-language materials were reviewed where identified.

This summary report does not provide an exhaustive summary of the peer-reviewed or grey literature; such a task was beyond the scope of this project. Rather, particularly in the context of non-Canadian literature where scoping and/or systematic reviews have been published in recent years, it captures the key findings of those reviews and updates them with more recent, relevant studies where applicable. In the case of individual studies, those from similar high-income countries have generally been considered more relevant, depending on the subject matter. In the case of Canadian literature, there is an attempt to include individual studies over at least the past decade, but some studies have been omitted where similar data has been reported more recently. In other instances, especially where relatively little literature exists on a specific point or population, particularly in relation to the Canadian context, some older studies or sources, including from beyond Canada, have been included if they seem still relevant.

Insights from key informants

A selected number of key informants who are members of the 2SLGBTQ+ community were interviewed for their insights. All but one identify as someone with personal experience of drug use. All of them work in the field of harm reduction and/or drug policy in some capacity. They drew upon their expertise to answer questions about: the needs of GBTQ2 people in relation to preventing, treating, and reducing the harm associated with problematic substance use, including sexualized use; barriers to, and facilitators of, access to needed information and services; considerations affecting specific populations of GBT2Q people; community organizing and community spaces, physical and virtual, for addressing substance use among GBT2Q people; funding needs and priorities; and possible legal, policy, and programmatic measures to better protect the health and human rights of GBT2Q people who use drugs. Key themes that emerged from those interviews are integrated into the summary of findings below, alongside the review of the literature.

NOTES ON TERMINOLOGY

Sexual orientation and gender identity

This project addresses harm reduction and other needs related to substance use among gay, bisexual, and other men (both cisgender and trans) who have sex with men, as well as Two-Spirit and non-binary people ("GBT2Q people"). Much of the research is specific to the narrower category of gay, bisexual, and other men who have sex with men (GBMSM), so much of what can be said based on the literature is best supported in relation to this particular population. However, this report and related documents also include some specific discussion of the situation among trans women, another population of concern that also experiences higher prevalence of problematic substance use (including sexualized drug use), HIV and other STBBIs, and unmet health needs. There are similarities to the situation of GBT2Q men, but also specific concerns and needs of trans women that warrant their own analysis, funding, and services.

In some instances, the broader, all-encompassing terms "sexual and gender minorities" ("SGM") or "LGBTQ+" are used when an observation applies to all lesbian, gay, bisexual, trans, or otherwise queer people more broadly. When referring to the Canadian context specifically, the acronym "2SLGBTQ+" is generally used, thereby also explicitly including persons who identify as Two-Spirit – a pan-(North American)-Indigenous term coined by Two-Spirit people that may "be used interchangeably to express one's sexuality, gender, and spirituality as separate terms for each or together as an interrelated identity that captures the wholeness of their gender and sexuality with their spirituality."[8]

Substance use

Unless referencing specific sources, this document generally avoids terms such as “addiction” or “substance use disorder,” which are often stigmatizing, and instead uses the term “problematic substance use.” This term is itself imperfect. It should not be misinterpreted as suggesting that substance use is inherently problematic. To the contrary, the qualifier “problematic” signals that there is also non-problematic substance use. In fact, most instances of substance use, regardless of the legal status of a substance, do not cause significant harm.[9] The frequency and/or intensity of use can become “problematic” for a person when it begins to cause actual harm or significant risk of harm, either to themselves or to another person. In the case of the person using the substance, this harm can come in the form of negative consequences in one or more domains of their life (e.g. health, work, relationships, legal difficulties) that they find disproportionate compared to the benefits of their use and that they wish were otherwise. In recognition of the agency and autonomy of people who use drugs, it is in this sense that this report uses the term “problematic substance use.”

Problematic use among LGBTQ+ people of any substance — including alcohol as well as psychoactive drugs, regardless of their legal status — is of concern. This report is focused primarily on the use of substances other than alcohol and uses the terms “substances” and “drugs” interchangeably, as does much of the literature. However, problematic alcohol use is also higher among LGBTQ+ people, often for many of the same reasons underlying problematic use of other substances, including ones that are connected to sexual and/or gender identity in the context of homophobia and transphobia. As such, it should be kept in mind that some of the other observations below, which relate to (problematic) substance use more generally among LGBTQ+ people, are also applicable to problematic alcohol use.

KEY FINDINGS

Substance use among GBT2Q people

Studies from multiple countries have found that GBMSM are more likely to report the use of substances, including criminalized drugs, than the general population.[10] There is now also a significant and growing body of research confirming this among GBMSM in Canada.[11]

The most recent national data comes from the 2021 national *Sex Now* survey, conducted by the Community-Based Research Centre (CBRC) and involving more than 5800 GBT2Q respondents nation-wide, of whom more than 3800 responded to questions about substance use. More than 90% reported using a substance within the past six months. As is the case with the population in Canada as a whole, across all demographics, the most commonly used substances were alcohol (used by 82% of respondents) and cannabis (used by 53% of respondents). A significant percentage of respondents indicated use of psychedelics (16.2%), ecstasy/MDMA (10.1%), cocaine

(9.9%), GHB (7.7%), crystal meth (7.6%), and ketamine (4.8%).[12] Other local or provincial-level research in recent years confirms the general observation about higher prevalence of substance use among GBMSM and/or among 2SLGBTQ+ people more generally.

While there is ample evidence of disproportionate substance use among sexual and gender minorities, fewer studies have examined problematic substance use by sexual orientation or gender identity.[13] However, studies in the US have demonstrated a greater risk for "substance use disorder" among MSM compared to men who do not have sex with men,[14] and data from a large survey of more than 6400 LGBTQA+ youth in Australia found not only high prevalence of drug use in the previous six months, but that nearly one quarter had been concerned about their own drug use.[15] In Canada, the national 2012 *Mental Health Survey* found that 18% of respondents who identified as lesbian, gay, or bisexual met the criteria for substance use disorder within the previous 12 months, compared to only 4% among self-identified heterosexuals,[16] and in 2017, in a survey of more than 700 GBMSM in Vancouver, 17.4% indicated having been diagnosed by a doctor with an alcohol or substance use disorder at some point in their life.[17]

While not all substance use is "disordered" or "problematic," greater prevalence of substance use in a population does give rise to a greater population-level risk of harms associated with that use. As presented below, there is also extensive evidence that with respect to (i) the use of substances; (ii) the factors associated with their use; (iii) risks and experiences of harm; and (iv) the services and policies needed,

- sexual and gender minorities *differ from heterosexual and/or cisgender people* in some important respects;
- there are some differences *between* sexual and gender minority populations; and
- different considerations exist *within* sexual and gender minority populations based on factors such as HIV status, gender identity, race, age, ability, engagement in sex work, income, incarceration, etc., and the intersection of such factors with sexual or gender identity and substance use.

Effectively responding to the real and warranted health and human rights concerns raised by the high prevalence of substance use among GBT2Q people requires attending to these realities.

Sexualized drug use

Clarifying terminology: sexualized drug use and chemsex/"party-and-play"

Over the past two decades a growing body of research has identified and characterized patterns of drug use among GBMSM that are also linked with sex. In recent years, the term **"sexualized drug use"** (SDU) has generally emerged as a broad term referring to the use of any drug before or during sex, while the term **"chemsex"** — in Canada, more commonly referred to within the GBT2Q community as **"Party and Play" (PnP)** — is often used more narrowly to refer to a sub-category of SDU, namely sex that is accompanied, before and/or during the

encounter, by the use of certain drugs in order to facilitate, prolong, disinhibit, or enhance the experience.[18] These purposes are, of course, highly relevant to efforts to reduce the harms that may arise for some who PnP.

There is no universally agreed definition of "chemsex."[19] While sexualized drug use is common across genders and sexualities,[20] some have considered the term "chemsex" to refer to the use of specific drugs, and specifically for sex-related purposes, by GBMSM,[21] although some have extended it to trans people[22] and yet others have applied it more broadly.[23] Some researchers have argued it is not helpful "to narrowly delimit chemsex as a narrow and uniform set of identifiable and determinable risky contexts and behaviours," as this is too simplistic and risks reinforcing incorrect and stigmatizing assumptions (e.g. about how and why GBMSM use substances, that all use is problematic, etc.), which ultimately also undermines more effective practice in responding to problematic chemsex. They instead argue for a more flexible and expansive use of the term to leave room for complexity, including GBMSM's strategies of harm reduction within chemsex practice.[24] Perhaps more important than the precise definition of the term is the observation that the experiences of GBMSM and other sexual and gender minorities — and the ways in which sexual and gender minority identities intersect with substance use — must not be erased or sidelined in the appropriation of a term that originally emerged specifically out of their social and sexual spaces and culture.

In any event, the term "chemsex" is elastic and used inconsistently, particularly with respect to which drugs are included in the definition for purposes of a given study.[25] The list always includes methamphetamine, GHB/GBL, and mephedrone (and sometimes other amphetamine-type stimulants). Ketamine, ecstasy/MDMA, and cocaine are often included, given the frequency of their use in conjunction with sexual activity to enhance or intensify the experience. Some researchers include substances that have less potential for problematic use but that are regularly used in a sexual context for these purposes, such as alkyl nitrites ("poppers"), which are associated with sexual practices posing higher HIV risk,[26] and erectile dysfunction medications (sometimes used to counteract the effects for some men of stimulants). Canadian data shows that for some GBMSM, cannabis is also used for chemsex.[27]

Adding to the confusion, while the terms "sexualized drug use" and "chemsex" are distinguished from each other in much of the literature, some studies use them interchangeably — and this is also sometimes the case in common parlance. However, this report uses the terms "chemsex" and "PnP" in the narrower sense described above, i.e. as a sub-category of sexualized drug use defined by the deliberate combination of certain substances with sex for the purpose of facilitating, prolonging, disinhibiting, or otherwise enhancing the encounter. While others also engage in what could be characterized as chemsex, this report focuses on the experiences and needs of GBT2Q people, given the ways in which substance use and sex(uality) intersect.

Sexualized drug use among GBT2Q people

Recent systematic reviews and multi-country studies have found that sexualized drug use is higher among GBMSM.[28] In 2019, Maxwell and colleagues published the first systematic review of published research on the antecedents, behaviours, and consequences associated specifically with chemsex (as opposed to sexualized drug use more broadly) among men who have sex with men.[29] They concluded that a minority of MSM engage in chemsex behaviours but they are at risk of this negatively affecting their health and well-being. Based on their global survey, Lawn and colleagues suggested that up to 45% of GBMSM have engaged in chemsex at least once, although a much lower proportion report recent or recurrent participation.[30] Much of the research to date has been done in North America, Oceania, and Europe,[31] but recent studies from Latin America and Asia confirm a higher prevalence of sexualized drug use among GBMSM in those regions as well.[32]

In the Canadian context, there have been numerous local and provincial-level studies over the past decade. CATIE reported in 2019 that, based on then available data, somewhere between 5% and 20% of GBMSM in Canada have participated in sexualized drug use.[33] In 2017, Canada participated, for the first time, in a multi-country internet survey originating in and covering most of Europe, the *European Men-who-have-sex-with-men Internet Survey* (EMIS).[34] More than 5000 GBMSM (including cisgender and transgender men) from across Canada participated. Of these, two-thirds (64.1%) indicated ever using any illegal substance, with cannabis (not legalized at the time), cocaine, and ecstasy as the most commonly used. Fewer than 5% of respondents reported using other substances within the previous year, such as ketamine (4.1%) or amphetamine (4.4%). (For purposes of comparison, note that, according to data from the most recent national survey on substance use among people in Canada, also conducted in 2017, past-year use of methamphetamine among the population as a whole was less than 1%.[35]) One-fifth (21.5%) of GBMSM participating in EMIS reported ever having participated in chemsex, and 5.8% of respondents had done so within the previous six months.[36] The researchers observed that: “Substance use was high and, for the first time, there are national data showing that over 20% of participants engaged in chemsex.” They concluded: “The EMIS-2017 findings point to the need for implementation research to determine best practices to address the high levels of discrimination, poor mental health and substance use harms that gbMSM experience.”

Substance use was high and, for the first time, there are national [Canadian] data showing that over 20% of participants engaged in chemsex.

— Brogan et al., 2019

The most recent nationwide data regarding substance use among GBT2Q people is from CBRC's *Sex Now* survey in 2021, of a similar sample size to EMIS-2017. Of those who answered questions about substance use, more than one-quarter (27%) reported using substances *during* sex within the past six months. This figure was similar across age, gender identity, and ethno-racial categories, but was significantly higher among respondents living with HIV (43%). Poppers, cannabis, and alcohol were the most used, but crystal meth, GHB, and psychedelics were also often used. [37]

Specifically in relation to the use of methamphetamine, since that national survey by CBRC, Berlin and colleagues have reported in 2022 further data from the ongoing Engage Cohort Study, involving nearly 2500 GBMSM in Montreal, Toronto, and Vancouver[38]. They note that an estimated 8-20% of GBMSM in Canada have used methamphetamine in the past year, mostly in a sexual context. From the Engage cohort data, they reported that 28% of men living with HIV and 4% of seronegative men reported using methamphetamine within the past six months. This latter figure seems a likely underestimate given the somewhat higher prevalence (4.4%) reported in the national EMIS-2017 survey noted above, the even higher figure (7.6%) reported in the CBRC 2021 national *Sex Now* survey noted above, and some earlier, local studies in Canada reporting a significantly higher prevalence: e.g. the report by Card and colleagues in 2018 estimating that 19% of GBMSM in Vancouver had used methamphetamine in the previous six months.[39]

Compared to the population as a whole, recent crystal meth use is at least four times higher among HIV-negative GBMSM and likely substantially higher, and is many times higher still among GBMSM living with HIV.

As for *how frequently* GBMSM use a substance such as methamphetamine, in 2020, McGuire and colleagues reported the results of the Crystal Methamphetamine Project. This project drew upon both in-depth interviews with 33 men across BC and the responses of 780 participants in a national survey, all of whom self-identified as men or non-binary people who, within the previous six months, had both had sex with a man and used crystal methamphetamine.[40] They found that just over half (55%) of respondents had used it at least weekly; the remaining 45% used it only a few times a month or less frequently. The following year, Card and colleagues reported on data from a sample of nearly 400 men across Canada who reported methamphetamine use within the previous six months. Just over one-third reported using daily or almost daily, just over another third reported using either weekly or monthly, and the remaining third reported using only once or twice within the past six months, the majority of whom reported using methamphetamine prior to or during sex.[41]

"Slamsex"

The use of chemsex drugs by injection — known as "slamming" or "slamsex" — is a well-known phenomenon, "but there is a lack of research examining MSM sexualised injecting of drugs."[42] Some studies indicate it has been associated with more significant harms to physical and mental health, including increased potential for transmission of HIV, HCV, and other STBBIs.[43] In the EMIS-2017 survey of GBMSM across Canada, 3.5% reported ever injecting drugs, although the report does not indicate whether this was in a sexual or non-sexual context.[44]

More recently, two Canadian studies provide some data specific to practices among MSM who report recent crystal meth use. In 2020, McGuire and colleagues reported that, among the 780 respondents to the national survey that was a component of the Crystal Methamphetamine Project, 58% had never injected, while 32% had injected within the past six months.[45] In 2021, Card and colleagues reported that in their national sample of nearly 400 SGM men, nearly one-quarter (23.3%) reported injecting methamphetamine. Two recent reviews of the broader literature found that: (i) the prevalence of slamming among MSM was highly variable across the studies, but methamphetamine and mephedrone were the two most frequently injected drugs;[46] and (ii) "traditional services are ill-equipped to address SIDU [sexualized injection drug use] because of a lack of knowledge of practices, lack of associated vocabulary, and a failure to integrate sexual health with drug services."[47] Researchers have explored the ways in which injection becomes eroticized as part of the sexual experience, how it constitutes forms of connection and norms of care among participants, and for some, a means of harm reduction by limiting how much they use (as opposed to smoking, which, for some men, would lead to greater consumption over an extended period).[48] (Pipe sharing when smoking crystal methamphetamine is similarly commonly eroticized and identified as an important social aspect of PnP.[49]) Researchers have also highlighted that "intersecting forms of stigma may discourage GBM from accessing supports which have historically targeted opioid-injecting and street-based drug use. Harm reduction interventions tailored for people who inject drugs may not be equally effective in addressing GBM-specific needs."[50]

Context of substance use among GBT2Q people

Responding effectively to problematic substance use among GBT2Q people requires understanding why and how people are using those substances. This section briefly summarizes some relevant considerations as identified in the literature and by key informants.

Reasons GBT2Q people use drugs

People use substances for physical and psychological pleasure, to alter consciousness, as part of spiritual practice or cultural tradition, to relax, to boost confidence, to connect socially with others (including sexually), to lower inhibitions, to relieve physical and emotional pain, to cope with stress, and to escape temporarily from life's problems or challenges. There may also be other specific, functional reasons to use particular substances. For example, depending on the user and approach, a stimulant such as methamphetamine and a depressant such as heroin might be used together to enhance the overall effect sought by the user, or one may be used to counter certain effects of, or withdrawal from, the other.[51] Stimulants enable people to stay awake and alert for extended periods: in some studies, sex workers have reported that its use enables them to work longer and see more clients,[52] while some people experiencing homelessness report using methamphetamine to stay awake to protect themselves and their belongings.[53] Some have described smoking methamphetamine as a weight loss strategy and, among those who experience food insecurity, as a way of reducing appetite and feelings of hunger.[54]

Nexus between substances, sexuality, and social location

All these reasons can exist for GBT2Q people who use substances. But reasons for use are also mediated through the experience of belonging to a sexual and/or gender minority — and especially in the context of sexualized substance use, there is a particular connection between sex(uality) and substance use for many GBT2Q people. There are historical and ongoing links between substance use and the spaces, physical and now virtual, that GBMSM access for social and sexual connection, where alcohol and other drug use is normative.[55] Social marginalization and discrimination, and the accompanying "minority stress,"[56] have been discussed extensively in the literature as factors contributing to higher prevalence of substance use, including problematic use, among 2SLGBTQ+ people.[57]

> *"For sexual and gender minorities, drug and alcohol use can be a creative or experimental response to social marginalisation — and not necessarily a problematic one in every instance."* [58]

In addition, "recreational drug use has been framed as a valued cultural practice among GBM, in part due to benefiting the formation of gay identities"[59] and "it is also a matter of historical record that certain communities and social relations have been brought into being through drug practices," including gay sexual subcultures.[60] For some, substances offer "one way of acting upon sexual desires and activities whose performance is otherwise foreclosed by the normative pressures of heterosexual culture and/or HIV prevention."[61] Both the quantitative and qualitative literature converge in documenting norms and attitudes within gay culture that support chemsex among GBMSM.[62]

> *"Substance use is sometimes associated with the celebration of positive sexuality and the loss of shame and inhibitions. Thus, for many G2G [guys into guys], taking drugs or drinking can be closely tied to how they hook-up and have sex. Some may feel that they need to take substances to have sex or to enjoy having sex. Because of this, shifting one's relationship to substance use (or to a specific substance) can sometimes be quite challenging, especially when substance use is tightly wrapped up with one's sexual identity and practices."* [63]

Both the literature and the key informants identify the strong connection for some GBT2Q people between the use of substances and their sexual lives and practices. Given this, addressing problematic use will often require at least a discussion of sexuality and, in the case of those who engage in problematic chemsex, will involve changing not only substance use behaviour but also sexual behaviour, another domain of life that involves strong psychological and physiological impulses. Several key informants noted this important point about the connection between sex and substances, which must be addressed if harm reduction or other interventions are to be effective.

Through the literature — which largely focuses on GBMSM — multiple reasons emerge for PnP, many of which were echoed by the key informants interviewed for this project.[64] As summarized by Knowles,[65] the literature indicates that GBMSM (and likely other gender-diverse people) incorporate drugs into their sexual encounters to:

- "increase their sexual confidence and help them overcome their self-doubt, body image issues, and sexual insecurities;
- increase their libido or sexual desire, which may have changed as they age;
- create a sense of community through participation;
- increase feelings of intimacy and sexual connection with sex partners;
- increase their sexual longevity, allowing them to have sex for longer periods of time without ejaculating or to be ready to have sex again soon after ejaculating — this can also allow for sex with more partners over the same length of time;
- participate in a more diverse range of sexual activities because of a loss of inhibition;" and
- "for some HIV-positive gbMSM, PnP may help them to deal with negative feelings arising from stigma and discrimination related to their HIV status and/or sexuality."

Pleasure

One key theme that emerges from the literature, and from discussions with the key informants, is the importance of acknowledging the benefits that people receive from their substance use, including sexualized drug use. The physical and/or emotional pleasure of an intensified, enhanced sexual encounter is obviously a primary motivation.[66] By way of illustration, in their survey of more than 1600 GBMSM in the UK, Hibbert and colleagues found that 41% reported sexualized drug use during the previous 12 months, and those who engaged in SDU reported greater sexual satisfaction, compared with those not engaging in SDU.[67]

> *"Why are people using crystal meth? One word: sex. Black and Latino MSM overwhelmingly described crystal meth use as a tool to enhance a sexual experience and to promote connection and intimacy."* [68]

Taking the centrality of pleasure into account is also key to designing and implementing interventions aimed at preventing, treating, and reducing the harms of use that becomes problematic. Twenty years ago, McFarlane and the LGBT Health Association of BC reported from focus groups that gay, bi, and trans men "stressed that reframing harm reduction messages as 'pleasure enhancement' messages would be more successful in gaining currency and attention."[69]

More recently, based on focus group data from the Meth@morphose project in Montreal, aimed at improving local services available to GBMSM who use methamphetamine, Flores-Aranda and colleagues concluded: "These findings question the content of methamphetamine use prevention campaigns, which mainly target the negative potential consequences of this form of substance use. By not taking into account the pleasure associated with the use of this substance, these campaigns are likely to fail…. However, the concept of pleasure, especially sexual pleasure, in relation to substance use, is seldom addressed in sexual health and addictions services."[70]

Similarly, key informants were unanimous in their assertions that substance use is not always or necessarily about coping with or escaping negative things; the pursuit of pleasure and other benefits is part of substance use for many GBT2Q people just as it is for others. But as some pointed out, interventions that solely focus on conveying that "drugs are bad and dangerous" could inadvertently reinforce the stigma surrounding drug use, which is a key barrier to seeking support. Simply focusing on the harms that may arise in connection with some substance use risks ignoring the experience of the person who uses, why they use in the way(s) they do, and what they get out of their use. Practically speaking, understanding these factors is necessary in order to more effectively support someone in modifying their behaviour to reduce their risk of harm and/or stop their use, depending on the goal — for example, by figuring out ways, other than through particular substance use or ways of using, that they can experience pleasure, community, connection, or the other positive benefits they derive from their substance use.

> *The conventional pathways for people who want to receive services in relation to chemsex are things like NA [Narcotics Anonymous] and CMA [Crystal Meth Anonymous]. Most people try those and get disillusioned because it requires abstinence and if they relapse, they're shunned. So, people try it that way, it doesn't work out and then they stop looking for help. What I've seen in individual and group counselling, the crystal meth and GHB use is closely connected to their sexuality, and experiences have been so intense they don't want to let go of it. So, one of the obstacles is defining a desirable outcome that is realistic, this is something that I hear again and again.*
>
> — Mathieu Mailhot-Gagnon, RÉZO (Montréal)

Connection

Another key motivation underscored by the literature and key informants is a desire for connection. As LaFortune and colleagues note, their review of the literature shows that it is important to also consider "…the social motives underlying engagement in Chemsex, notably as a means to develop sexual intimacy and emotional closeness, an opportunity to strengthen belonging to a community (e.g., friends, sexual scenes), or an escape from patterns of marginalization and loneliness."[71] This is especially relevant as GBMSM report high rates of loneliness.[72] As Bryant and colleagues put it, drug use can "serve to establish belonging in contexts of social exclusion,"[73] or as one therapist observed, "for men who feel different or isolated, chemsex can come to be their community and place to connect."[74]

How a sense of connection and community operates in relation to GBMSM's chemsex practices is complicated. For example, Hawkins and colleagues have reported that substance use can both facilitate and inhibit entrance into gay community settings among GBMSM in Vancouver.[75] At the same time, other research, involving qualitative interviews with GBMSM in Halifax, Ottawa, and Vancouver, reveals that the link between sexualized drug use and community can be a powerful factor contributing to substance use becoming problematic and more difficult to manage, ultimately contributing to isolation, including as a result of the stigma surrounding drug use and chemsex in particular.[76]

More positively, a desire for pleasure and connection can exist without being rooted in loneliness and this desire has been found to feature prominently in the motivations for sexualized drug use among GBMSM, including in Canadian studies.[77] For example, in a study among GBMSM in Toronto, "[p]ipe sharing was widespread among participants and was deemed integral to the social experience of smoking crystal methamphetamine."[78] A study among more than 700 gay and bisexual men living with HIV in Australia found that, on self-reported measures of general health, wellbeing, and general social support, there was no difference between men who used PnP drugs and those who did not, but men who reported use of PnP drugs reported higher levels of resilience and lower levels of perceived HIV-related stigma; this was associated with spending more time with other people living with HIV and lesbian/gay friends. The researchers concluded that the social contexts in which PnP drugs are used may provide wellbeing benefits, particularly for gay and bisexual men living with HIV.[79]

In a similar vein, Beijamal conducted a survey among GBMSM in Toronto regarding their "satisfaction" with their gay community, investigating how such sense of satisfaction correlated with their sexual activity and substance use, and the combination of the two. He reported that a higher proportion (nearly two-thirds) of men who used "party substances" — defined as including crystal meth, GHB, cocaine, ketamine, MDMA/ecstasy, erectile drugs, and poppers — reported being satisfied with their community than that of men who did not use these substances. Similarly, a greater proportion of men (almost two-thirds) who had engaged in chemsex specifically (i.e. using party drugs during their sexual encounters) reported community satisfaction than among men who did not engage in chemsex. Beijamal concluded that the results suggest that there is an "invisible population" of men who use substances who are coping well and perhaps this can be attributed to a sense of community among men who PnP, with community functioning as a protective factor against the adverse effects of using substances. He speculated that, as with embracing a queer identity in a heteronormative world, perhaps identifying as part of the PnP community also creates group cohesion in a world that is drug prohibitive.[80]

Connection similarly emerged as a key motivation for use in the Crystal Methamphetamine Project, the results of which were reported by McGuire and colleagues in 2020. Nearly half the participants identified "connecting with others sexually" as the main reason for their use, while a quarter identified "connecting with others socially" as a reason. As the researchers note:

> In addition, a common theme among interview participants was that they felt that being part of the PnP community had led to deeper connections and lasting friendships… Sex is an important part of socializing and community for many gbMSM, and sexuality is one of the ways, through identity and practice, that social circles and relationships are formed. Patterns of substance use among gbMSM are also shaped by the presence of sex and sexuality in community and social spaces, with many gay, bi, and queer men choosing to use meth in sexual and social contexts due to its positive effects on pleasure, intimacy, and social connectedness.[81]

It is also worth noting that, in identifying important characteristics of what supports and services should look like for people seeking help with problematic methamphetamine use, the themes of connection and care recurred: two-thirds of respondents said that it was important that a program "includes social activities with other guys" and 70% identified as important that "the program gives me opportunities to help other participants."[82]

Consistent with the literature, several key informants spoke about not only the connection that can form between sex and substance in the context of sexualized drug use, but also the sense of connection and community that can form among men who PnP specifically — which is the flipside of the isolation arising out of the stigma related to chemsex. This can also complicate efforts to reduce or cease using for those for whom this is the goal. Relationships may exist beyond just the sexual, making it more challenging to end the PnP connection while maintaining the friendship. With sex and substances — and possibly social connections — so intertwined, the cost of stopping substance use becomes even greater. Abstinence represents not only the loss of pleasure and/or a means of coping with or escaping from life's challenges, but for some, the loss of friends (with benefits), of a social circle, of a sense of belonging. Even more profoundly, it can mean the loss of a sexual life and identity — one that, for many, was established at considerable psychological and sometimes physical cost, against the expectations and edicts of a heteronormative and rigidly gendered world that is often actively hostile to the existence of sexual and gender minorities.

> *We're dealing with the sexual sphere and the social sphere, two parts of one's life that are very significant. When people stop doing chemsex, sometimes they let go of all their friends, but they also have to let go of sex, sometimes for months or more, and some of them grieve their sexuality.*
> — Mathieu Mailhot-Gagnon, RÉZO (Montreal)

The literature and insights from many of the key informants underscore that support for GBT2Q people struggling with problematic drug use, including in a sexualized context, needs to include opportunities for connection, and for the creation of community, independent of substances.[83]

Virtual (dis)connections

Sexualized drug use is neither new nor limited to GBT2Q people. But the emergence of "chemsex" or "PnP" as a specific category of sexualized connection has coincided significantly with the rapid spread of online technologies, including the use of social networking platforms (both websites and smartphone apps) among GBMSM that facilitate both sexual encounters and access to substances — to the point that such technologies are seen by some as central to the emergence of "chemsex" and as one of its defining, or at least highly significant, features.[84] Alongside the decline of public spaces of gay social life has been the corresponding "virtualization" of queer community, as described by Numer and colleagues.[85] As they point out, this is noteworthy not only because of the predominance now of such virtual space as the environment within which GBMSM meet for sexual encounters and relationships, but for the immediacy and constancy of access to such space.

These platforms play a significant role in the sexual lives of many GBT2Q people,[86] in part because of their accessibility, affordability, and anonymity.[87] As such they shape community norms and perceptions regarding sexual identity and practice. They facilitate easier access to both sex and substances, and feature prominently in PnP/chemsex practice[88] — a common combination of apps, sex, and drugs that is a community cultural practice that Holmes and colleagues term "wired sex."[89] Consequently, they are key features in the relationships that GBT2Q people who use them have with both sex and substances. Therefore, they are also spaces that cannot be ignored, and that have significant potential benefit, in efforts to reduce the harms of problematic substance use among GBT2Q people.

The ongoing COVID-19 pandemic has accelerated the virtualization of many activities. This has included the use of video conferencing platforms for GBT2Q people who PnP to create new social networks and to hook up digitally.[90] As one service provider interviewed by Holmes et al. observed:

> In addition, a common theme among interview participants was that they felt that being part of the PnP community had led to deeper connections and lasting friendships… Sex is an important part of socializing and community for many gbMSM, and sexuality is one of the ways, through identity and practice, that social circles and relationships are formed. Patterns of substance use among gbMSM are also shaped by the presence of sex and sexuality in community and social spaces, with many gay, bi, and queer men choosing to use meth in sexual and social contexts due to its positive effects on pleasure, intimacy, and social connectedness.[91]

Similarly, such technologies enable virtual connection to harm reduction and other support services for GBT2Q people — e.g. "virtual drop-in" spaces or counselling and peer support sessions via Zoom or similar platforms. While limited, research confirms a need and demand for online outreach services for GBT2Q people using various information and communication technologies (ICT), including via such social networking platforms — because they allow greater anonymity, facilitate access to populations that face greater barriers to connection to an identifiable gay community or to in-person services (e.g. stigma, distance,[92] age, ability, etc.), allow

faster access, and lend themselves well to a peer model of outreach.[93] All key informants spoke of providing services virtually, in some cases before COVID-19 but in other cases as an adaptation in light of it; some spoke specifically of the need for such online engagement. This includes not just the distribution of information about safer sex and drug use or how to connect with various services, but also interactive tools (e.g. the MonBuzz/MyBuzz self-assessment tool described below), individual and group counselling, and forms of virtual peer support. Some observed that such access, including in modes that allow someone to remain unidentified, are important as a means of increasing greater, more equitable access to services:

> *"Online spaces are key to addressing sexualized substance use but the risk service providers run when we come into these spaces wearing professional hats is that we are perceived as interlopers. We're invading a very private, clandestine space, where community holds safety and discretion dear. We need to strategize about how to support peers to engage in those spaces in a less intrusive, less formalized way to be advocates for harm reduction. The anonymity available online can be a facilitator for people to engage, going to attract more people than asking people to come into an agency that is identified as being for substance use or HIV. The building can be a barrier."* [94]

> *"It's absolutely critical to have such virtual spaces that allow guys to connect and get support with less fear of being outed about their sexuality or drug use, but these don't replace that sense of community, of connecting in person. We need all of it, really."* [95]

Lack of collaboration by operators of online platforms can be a barrier to effective outreach[96] — and there is a mixed track record on the part of such companies. For example, some hook-up apps have been willing to willing to occasionally carry advertising of harm reduction information or tools (e.g. the MonBuzz.ca/MyBuzz.ca tool). Yet the same apps simultaneously purport to censor their users. Many have banned the use of certain words (e.g. "party") or images that indicate an interest in sexualized drug use with sexual partners, and enforce such bans — albeit inconsistently — by suspending or permanently blocking user accounts for breaching the rules.[97] In fact, *Grindr*, the largest gay hook-up app, not only expressly bans any mention of the use of criminalized drugs but even threatens to identify site users to law enforcement if it deems it "appropriate."[98]

More recently, in 2022, *Squirt.org*, a global hook-up site for GBMSM operated by the Toronto-based Pink Triangle Press (PTP), advised users that it was removing "Party & Play" from the possible tags users could attach to their profile, thereby also precluding searching for other site users using this tag, on the stated basis that drugs are illegal — even though the tag had been available for years in the same legal environment and the gay sex the website facilitates is also illegal in many jurisdictions. [99]

Unsurprisingly, users of these platforms have adapted with cryptic workarounds to nonetheless communicate those interests. As Patten and colleagues note, "GBMSM use a variety of terms and symbols as coded language that is understood to signify SDU [sexualized drug use]. Censoring SDU language may lead to stigmatization and further risk-taking behaviour."[100] Holmes et al. note that service providers working with GBMSM reported that codes used on social networking platforms to avoid such censorship can also breed misunderstandings between those seeking encounters.[101] Key informants consulted for this project saw no value, and some harm, in such policies.[102] They certainly recognized, as does the literature, that access to such apps can also make it challenging for people who are seeking to abstain from substance use, because of the way in which they facilitate access to substances and connections with sexual partners with whom they can PnP. But none of the key informants were of the view that the measures taken by the apps (or site in the case of Squirt.org) impeded this in any way, and several criticized such measures as stigmatizing and counterproductive.

"I don't think it impedes in any way people talking about chemsex or PnP, because people find other ways or use emojis. It's very easy for people to identify who is doing chemsex, and word goes around about who might be able to sell you crystal and at a good price. And I think it makes it really difficult for a lot of men to stop using. They can delete the number of the person they get it from or who they PnP with, but then they go back on the app and that person is right there, so it's really hard to break that chain of accessibility of the substance." [103]

"You've got a bunch of apps corporations that aren't necessarily GBMSM-run but make a profit off our community. And some owners of these apps are very anti-drug, so drug discussion on apps is clamped down on or outright forbidden. Allowing people to talk about drug use on these platforms is incredibly important to keeping people safe and health, it's not promoting drug use." [104]

"It's asinine and stupid for these hook-up apps to state that you can't use this app for party-and-play. People are getting around that. You tell us no, we're going to find a way." [105]

Along with suggestions about how best to use hook-up apps and websites to strengthen harm reduction outreach and support, there is information in the literature, and practice models, regarding other digital interventions to respond to problematic substance use. There are some encouraging examples and results reported when it comes to technology-assisted interventions,[106] and World Health Organization (WHO) guidelines on HIV and other STI prevention recommend that virtual interventions be included in the approach, as complementary to in-person services.[107] *Text messaging interventions* with social support and health education content transmitted in real time has been found helpful to GBMSM in reducing their frequency of methamphetamine use and condomless sex while using it.[108] *A web-based intervention* aimed at reducing drug use among sexual minority young people —

consisting of three short sessions building their skills for identifying and managing stress, making decisions, and examining their drug use rates and refusing to use — has also shown positive outcomes.[109] Some preliminary results from recent research suggests that the addition of brief computerized interventions for depression may assist GBMSM in reducing their use of methamphetamine and sexual risk-taking.[110] Platteau and colleagues argue that, as GBMSM are avid users of digital communication technologies for social and sexual connections, including in relation to chemsex, these offer opportunities for interventions to provide support and care.[111] Such efforts are consistent with previous Canadian research exploring the relationship between online sex-seeking, community/social attachment, and sexual behaviour among GBMSM, and recommending that both internet and community-based interventions be used to reach website and app users in promoting safer sex.[112]

Harms associated with substance use among GBTQ2 people

HIV, HCV, and other STBBIs

Studies in various countries have identified the strong association between substance use — particularly sexualized substance use — and risk of HIV, HCV, and other STBBIs among GBMSM.[113] Some studies have also reported that chemsex — particularly "slamsex" — is associated with an increased likelihood of acquiring HCV[114] and mpox.[115] Canadian data gathered over the past decade has similarly substantiated the concern about sexualized drug use playing a role in contributing to new infections with HIV, HCV, and other STBBIs,[116] given its association with: a greater number of sexual partners;[117] sexual acts posing a higher possibility of transmission (although this landscape has been changing with the scale-up of HIV treatment among men living with HIV and of pre-exposure prophylaxis among men who are HIV-negative);[118] and the sharing of injection equipment. For example, among nearly 400 SGMSM (sexual and gender minority men who have sex with men) from across Canada who reported methamphetamine use within the previous six months, nearly one-quarter (23.3%) reported injecting it, and of these, more than 1 in 5 (21.7%) used shared syringes.[119] These figures indicate that GBMSM would benefit from evidence-based interventions that address both HIV and syndemic factors, including mental health and substance use concerns.[120]

Most recently, using data gathered from nearly 2500 GBMSM in Vancouver, Toronto, and Montreal via the Engage Cohort Study, Hart and colleagues examined the causal pathways between crystal meth use and STIs.[121] They found that "not all crystal methamphetamine use is equal": among those reporting its use, negative attitudes toward condoms, and "escape motives" (i.e. the expectation that substance use will lead to greater enjoyment of sex by enabling disengagement from negative thoughts, emotions and sexual pressures), were associated with condomless anal sex and with a greater number of partners. They observed this data reinforces the need for harm reduction efforts to address the STI risks (and other sexual health-related risks) among GBMSM who use crystal meth. This requires not only more and better access to care that can respond effectively to this population, but also better coordination and integration of sexual health services and services responding to mental health and substance use needs (e.g. the delivery of services related to substance use via sexual health clinics already reaching GBMSM).

Overdose and overamping

Some earlier U.S. studies have found that being lesbian, gay, bisexual, or transgender has been associated with a higher risk of experiencing overdose.[122] In 2019, Moazen-Zadeh and colleagues lamented the limitations with the existing data on this point, but nevertheless concluded that the available evidence points to overdose likely being substantially higher among sexual and gender minority people.[123]

Overdose is an obvious concern among people who use opioids, particularly given an illegal market heavily contaminated with fentanyl and other potent opioids as is the case in Canada.[124] There is also some evidence that a significant number of people use methamphetamine as an intended harm reduction measure based on the (incorrect) belief that it will reduce the risk of an opioid overdose.[125] The potential for overdose also exists with certain chemsex drugs — such as ketamine (a fast-acting anesthetic producing a dissociative and pleasurable effect) and GHB/GBL (a depressant that also has euphoric and sedative effects) — and even more so if used in combination with other substances, particularly those that depress the central nervous system (e.g. alcohol, opioids).[126] GBMSM may be a heightened risk for overdose, given that GBMSM have disproportionately high rates of problematic substance use, but "there is a substantial gap in our understandings about how overdoses are occurring within other key populations not conventionally identified within the overdose surveillance data, including among young … 2SLGBTQ+ people."[127] Data from the Manitoba 2SGBQ+ Men's Health Study showed nearly 1 in 5 (19.3%) reported that they had experienced an overdose at some point (and only 6.8% reported using naloxone).[128] But in contrast, some data more recently reported from Vancouver, focused on people (of all ages) in three prospective cohorts of people who use drugs who reported crystal meth use, did not find an association between MSM identity and overdose risk.[129]

Stimulant overdose ("overamping") is of growing concern as the increase in use of methamphetamine (including among GBMSM) is intertwined in the ongoing crisis of deaths following the use of (ostensible) opioids from the unregulated illegal market.[130] There has been a recent increase in overdose deaths apparently involving stimulants alone, in both the US and Canada.[131] In Canada, the available data suggest that the use of methamphetamine among people who use drugs has risen sharply in recent years,[132] and the number of hospital admissions[133] and deaths involving stimulants also appears to be rising: of the accidental apparent stimulant toxicity deaths between January and September 2022, 63% involved cocaine, while 52% involved methamphetamine.[134] Cases of cardiac arrest have been documented, and as noted below, more frequent and longer-term use of some stimulants can significantly increase the risk of fatal stroke. But overall, the phenomenon of stimulant overdose is less well defined and understood; harm reduction efforts should address this so that users (and service providers) can better identify the signs of overamping and be better equipped to respond.[135] Given their higher prevalence of stimulant use, this is of heightened relevance to GBT2Q people.

Mental health issues

Data from studies among GBMSM suggest a two-way relationship between problematic sexualized drug use and poor mental health for some — and hence the importance of addressing these as interconnected health problems: a history of mental health issues can contribute to problematic use; in addition, substance use can cause harm to mental health.[136] GBT2Q people are already a population with a higher prevalence of mental health concerns given experiences of homophobia, transphobia, violence, and trauma.[137] A range of mental health concerns relate to substances that are among those more commonly used by GBT2Q people, including in the context of chemsex/PnP. Again, methamphetamine, the most commonly used (criminalized) amphetamine,[138] is the substance that causes the greatest concern, with systematic reviews and meta-analyses suggesting a significant association between "psychotic disorders" and both methamphetamine *use* generally (particularly more frequent use)[139] and amphetamine use *disorder* specifically, although high-quality population-level studies are needed to more accurately quantify the risks.[140] Persecutory delusions, auditory and visual hallucinations, hostility, depression, and conceptual disorganization are central among such symptoms.[141]

Among GBMSM, a recent systematic review reported that those who practice SDU were more likely to experience depression, anxiety, or a substance dependence, although these results were not found in all the studies analyzed and mental health symptoms were more severe among those who reported injecting drugs for chemsex.[142] However, the authors caution that: "The findings found in these studies do not allow us to conclude that practicing chemsex in itself is a risk to poorer mental health. This may be partly due to the question of whether these mental health outcomes are directly related to chemsex practice or, to some extent, represent a priori vulnerabilities." Furthermore, they observe that: "Not all MSM who engage in chemsex experience mental health symptoms… The findings of this review suggest that problematic drug use in sexual contexts might only occur in a minority of men who practice chemsex." In what appears to be the first systematic review of the relationship between chemsex (among GBMSM and trans people) and the development of "psychosis,"[143] Moreno-Gámez and colleagues reported that in the studies reviewed the percentage of participants reporting "psychotic symptoms" ranged from 6.7% to 37.2%, and injection of drugs ("slamsex"), polydrug use, and smoked methamphetamine use posed up to a three-fold increased risk of psychosis.[144]

Physical health issues

There is significant literature regarding a range of harms to physical health associated with long-term use of various substances, including those frequently used in the context of chemsex.[145] Again using the example of methamphetamine for illustration, concerns include *cardiovascular* damage,[146] as well as *pulmonary* damage and damage to the immune system.[147] Specific concern has been raised that methamphetamine use could *exacerbate progression of HIV*.[148] Research has reported systemic inflammation in both the brain and gut associated with methamphetamine use,[149] and studies among young GBMSM have found that methamphetamine use has been associated with a microbial imbalance favouring pro-inflammatory bacteria in the *gastrointestinal microbiome*, including some that have previously been associated with poor HIV outcomes in those living with HIV.[150]

There are numerous studies documenting the neurotoxicity of methamphetamine use,[151] including its involvement in strokes, Parkinson's disease (although rare), and seizures, as well as neurocognitive impairment — although specifically with respect to claims about adverse impact on cognitive functioning, Hart and colleagues have challenged some simplistic claims made in previous studies that are methodologically suspect, and have suggested it is not clearly established that in fact there is a clinically significant impairment. [152] *Dental health* is another concern: long-term use of amphetamine has been associated with severe dry mouth, gingivitis, gum disease, cavities, and fractured teeth,[153] although again it has been suggested that the evidence linking methamphetamine use and tooth decay is anecdotal and that the popularly reported phenomenon of "meth mouth" has less to do with pharmacological effect of methamphetamine and more with non-pharmacological factors such as poor dental hygiene and media sensationalism.[154]

Poly-substance use can increase the risk of harm, given the potential for *harmful interactions between specific drugs;* there is also the potential for interaction between certain HIV medications and recreational drugs.[155] Finally, concerns have also been raised about an *increased risk of sexual violence* in some chemsex contexts, given the potential for impaired judgment and, with some drugs (e.g. GHB/GBL, ketamine),the potential for overdose that could leave a person unconscious.[156]

Legal, employment, and relationship issues

As a result of the criminalized status of most substances used recreationally, drug use also carries the risk of legal sanctions (and the harms to health that may arise from imprisonment if such a sentence is imposed). Canada criminalizes possession of various substances, as well as *possession for the purpose of trafficking* and *trafficking* (which includes any act of giving drugs to another person, including social sharing among friends or sexual partners, even for free.)[157] Given the prevalence of use, the threat of such sanctions obviously does not constitute a significant deterrent for a substantial number of people. However, in addition to infringing upon various human rights, the policy choice of criminalization does cause other multiple harms, including to the health of people who use drugs.[158] Studies have also shown, including among GBT2Q people, that a significant minority have experienced detrimental impact of substance use on their work (e.g. missing work, loss of employment), income, housing, and/or family and other social relationships,[159] at least some of which consequences are partly the result of stigma and discrimination and, directly or indirectly, the criminalization of people who use certain substances.

Thinking critically about the "problems" and "harms" of substance use

In keeping with the importance of acknowledging the benefits, including pleasure and connection, that people seek through substance use, it is essential to guard against the moral panic that so often accompanies discussions of drugs and sex — and particularly a phenomenon such as chemsex/PnP, which fuses the two. Amundsen and colleagues have flagged the potential bias in the research that may overstate at least some of the harms, such as the observation that about one-third of studies examining chemsex recruited exclusively from clinical settings. [160]

Schwartz and colleagues have made a similar observation about the systematic bias in the research toward identification of poppers-related harms, while disregarding poppers-related benefits.[161] And as Schroeder and colleagues have noted, from their review of the most influential research studies of substance use among GBMSM published during the past twenty years, the public health framing has often pathologized GBMSM's substance use and contributed to stigma, highlighting the need for more critical thinking and practice.[162] A similar concern was articulated in this fashion by one of the key informants for this project, someone who has spent years working in harm reduction (including in relation to PnP):

> *"Sometimes, the public health approach to GBMSM and substance use can be part of the problem. GBMSM are already over-surveilled by public health — our sex lives are a public health concern. Because public health has a narrow, highly problematized view of what PnP is (bareback, multiple partners, anonymous and extended sessions) and has linked PnP to increases in HIV and other STBBI infection, anyone who parties and plays is part of this 'crystal meth epidemic' we've seen reported on, although the prevalence of crystal meth is very low in comparison to other drugs used in the community. The hyper-focus on PnP leads to further monitoring of GBMSM and contributes to the stigma, including against guys who are HIV+. Addressing PnP is important, but it cannot come at the expense of attention to other substance use concerns that affect more people, such as alcohol use among GBMSM."*[163]

Bryant and colleagues have also criticized the "rush to risk" — i.e. "the tendency in much research towards problem inflation, including that view that methamphetamine use is inevitably problematic regardless of the ways in which it is used."[164] They have cautioned against overly individualized understandings of the relationship between methamphetamine use and sexual risk, and instead urged more careful research that seeks to better understand the different ways in which GBMSM use it, the contexts of use, and the social functions it serves — what others have characterized as "gay ways of using."[165]

> *"Many of the sites that epidemiologists identify as pathogenic are also key sites for the elaboration of significant social bonds. In these spaces, participants are undertaking some of the affective groundwork from which relations of* ***community, care and connection*** *may emerge."* [166]

In this spirit, Ismail and colleagues from the Gay Men's Sexual Health Alliance (GMSH) in Ontario have described how they sought to "reconcile the epidemiological definitions of PnP prevalent throughout the [health and social care] sector with the insights of people who PnP" in developing a public health education and prevention campaign to respond to chemsex as a behaviour contributing to increased transmission of HIV and other STBBIs among GBT2Q men.[167] As they note, the GMSH is committed to preventing HIV/STBBI infections and treatment failure among 2SGBTQ+ men, but it "also sees the need to mitigate the 'risk and danger'-based narratives associated with 2SGBTQ+ identities and cultures. It recognizes that these stigmatizing, disempowering narratives can affect the resilience, health and well-being of 2SGBTQ+ men." Of note, they describe how focus groups with men who PnP to review the draft content of a website and digital resources had a significant impact in rethinking the design of the campaign, including through recounting their personal experience:

[T]he stories that emerged profoundly centred on participants' demotivating experiences of being stigmatized within their own community. These experiences led to social alienation, challenges getting dignified and meaningful healthcare relating to their PnP and a broader culture of silence that was disempowering to them. Despite these challenges, what also came through in the discussions were themes of supportive community networks, caring practices within these networks and strategies of resilience that were life-affirming. These run contrary to the predominant narratives surrounding PnP. Even more revealing was the heterogeneity of participants' experiences of PnP: it became increasingly evident to us that there were diverse groups within the population of 2SGBTQ+ men who PnP, highlighting the need for nuanced and multiple strategies for meaningfully engaging these groups in health promotion.[168]

Specific GBT2Q populations

Among GBT2Q people, different identities and social locations also intersect to shape different populations' use of substances, their patterns of use, and the health implications of substance use. Understanding these differences is important in determining how best to protect and promote the health of all GBT2Q people. While a full discussion of all these considerations exceeds the scope of this summary report, some key considerations are identified below.

As noted above, substance use, including sexualized drug use, is more prevalent among **GBMSM living with HIV**, [169] and some studies suggest it has a detrimental impact on clinic attendance and adherence to antiretroviral therapy (ART)[170] and may *exacerbate HIV disease* progression and impact,[171] while some *ART could enhance exposure to certain recreational drugs*, increasing the possibility of intoxication or overdose.[172] Harm reduction education for people living with HIV needs to include this information and support for maintaining HIV-related care. **HIV-negative GBT2Q people** who use substances, particularly in the context of sexualized drug use, are a priority population for scaling up pre-exposure prophylaxis (PrEP) to reduce HIV risk and are receptive to its use. [173] While concerns have been raised that substance use (especially of alcohol and stimulants), might adversely affect PrEP adherence, the bulk of the evidence demonstrates the effective use of PrEP among GBMSM who engage in chemsex.[174]

The limited literature on this point, including Canadian data, suggests higher levels of substance use — and problematic substance use — among **bisexual men** in comparison to gay men, but also that it may differ in terms of sexual context, with less of the strong association between sex and substances characterized as "PnP" among gay men.[175] In a recent scoping review of the literature regarding opioid use and outcomes (e.g. overdose) among LGBTQ+ populations, bisexuals appeared to be at highest risk for problematic opioid use (although some other studies found that gay men faced the greatest disparities compared with heterosexual men).[176]

Services need to be destigmatizing and trans-inclusive and designed with the awareness that many people have had negative experiences when accessing services.

— Jess Murray, Queer and Trans Health Collective (Edmonton)

Among **transgender** people, the literature overall confirms a high prevalence of substance use generally when compared with cisgender people, correlated with "transphobic discrimination or violence, unemployment and sex work, gender dysphoria, high visual gender non-conformity and intersectional sexual minority status."[177] As for *problematic* substance use among trans people, the available data is limited and mixed, and there are conflicting interpretations. A recent scoping review by Paschen-Wolff and colleagues regarding opioid use and outcomes among LGBTQ+ populations found that only one of the studies explicitly measured gender identity,[178] although an additional study published soon after their review found trans individuals had a higher prevalence of opioid use disorder (OUD) diagnoses than cisgender individuals.[179] The bulk of the limited literature that exists focuses on *trans women*;[180] the literature regarding substance use among trans men, of various sexual orientations, is more sparse.[181] Canadian data about use of chemsex drugs among trans men suggests it may not differ significantly from use by cisgender GBMSM or perhaps be less prevalent.[182] Whatever the limited data may suggest regarding *sexualized* drug use among trans men, overall, the available data suggest greater prevalence of substance use among trans people,[183] and concerns associated with such use, including past-year stimulant use associated with higher risk of sexual exposure to HIV among trans men.[184] A 2019 national survey among trans and non-binary youth found that alcohol and cannabis are by far the most commonly used substances, but nearly one-fifth (19%) of youth reported use of prescription pills without a prescription, with mushrooms (15%) and ecstasy/MDMA (12%) the next most common, while 6% reported ever using amphetamines, 3% reported use of crystal methamphetamine, and 3% reported use of ketamine,[185] higher than among the population as a whole. While prevalence of substance use, and hence the potential for harm, is higher among trans people, they often face additional discrimination in access to services.

"When you are visibly queer, you may not necessarily feel safe around health care and service providers (let alone police or ambulance services). When you're visibly trans or queer it adds another layer of discrimination that makes it even harder to reach out for life-saving support. Overdose rates in these communities are much harder to track, and no government health care service is looking at these deaths. If I died today, the coroner's report would say 'M'[for gender] not only making me invisible as a trans person, but also contributing to the lack of awareness that this is a real issue." [186]

The situation for **Indigenous 2SGBTQ+** people is marked simultaneously by both an abundance and a paucity of data to inform the response. There is extensive evidence that Indigenous people in general experience higher rates of personal trauma (including assault, abuse, and systemic racism) than the population in Canada as a whole, as well as intergenerational trauma arising out of centuries of cultural genocide, dispossession of lands,

and destruction of family and kinship connections.[187] Both the Truth and Reconciliation Commission of Canada (TRCC) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG) have highlighted the ways in which such government policies of colonization have produced or contributed to the health challenges facing Indigenous people and communities; they also underscore the resilience of Indigenous people and communities in the face of such harms.[188] Punitive drug laws, rooted in racism and colonialism,[189] have been among those harmful policies, contributing in multiple ways to ongoing health and other inequities among Indigenous people.[190] These include significant over-representation among those experiencing incarceration (and the health harms that follow, including reduced life expectancy),[191] as well as higher prevalence of problematic substance use,[192] overdose/poisoning from the toxic unregulated illegal market,[193] and HIV and related harms.[194]

> *"The disproportionately greater harm from substance use experienced by Indigenous people… is not a drug crisis but a colonial crisis and a trauma crisis…. While our response has to include the appropriate treatment of harmful crystal meth use, if we want to prevent further crises, we also have to focus on the root causes of trauma and colonization and provide spaces and programs where people can rebuild their connections, their meaning, their belonging, their purpose and their hope."* [195]

Community researchers and advocates have also highlighted that problematic substance use and other contemporary health challenges that Indigenous 2SLGBTQ+ people face, such as violence, abuse, and HIV/STBBIs, have their roots in such colonization. This includes the deliberate destruction of traditional cultural roles and authority that Two-Spirit people enjoyed among many peoples indigenous to North America — through, for example, the sexist, gendered structures imposed under the *Indian Act*, and the imposition of Christian teachings and the residential school system, which stigmatized sex and sexuality and promoted a rigid gender binary and hegemonic, homophobic conceptions of masculinity, while subjecting many to sexual and physical abuse.[196]

The health of 2SLGBTQ+ Indigenous people specifically — including questions of sexual health and of substance use — has been the subject of little research until recently.[197] However, some studies that do exist suggest that, in comparison to cisgender and/or heterosexual Indigenous people, to non-Indigenous 2SLGBTQ+ people, and to the population of Canada as a whole, people who are both Indigenous and 2SLGBTQ+ face higher levels of poverty, homelessness, emotional distress, abuse and violence, and substance use, including problematic substance use. [198] The literature also speaks to Two-Spirit men coping with the dual challenges of the effects of colonization and racism as well as homophobia and/or transphobia.[199]

Where there *has* been some more concentrated research is in the area of HIV, which has hit Indigenous communities hard, with injection drug use as the major driver.[200] Data gathered in the context of HIV

surveillance include the most recent data from the national Tracks Survey, conducted among people who inject drugs in 14 sentinel sites between 2017-2019, in which 42% identified as Indigenous (although Indigenous people constitute approximately 4.9% of the population in Canada as a whole according to the 2016 census). Of these Indigenous participants, 13.5% identified as gay/lesbian, bisexual, or Two-Spirit and 2.6% identified as trans; these figures suggest a disproportionate representation of 2SLGBTQ+ people among this population of people who inject drugs, which is consistent with the well-established observation of higher prevalence of substance use among sexual and gender minorities. The Tracks Survey data show, among Indigenous people who inject substances, not only elevated HIV and HCV prevalence and gaps in the testing-and-treatment care cascade, but also significant deficits in access to the social determinants of health (e.g. education, housing, income) and a high prevalence of experiencing violence and abuse, stigma, discrimination, and incarceration.[201] Remarkably, and in a testament to their resilience, most (84%) reported their mental health as "fair to excellent" despite such statistics.

Stimulants were the most commonly injected substances, while opioids were used by a substantial minority, and a substantial minority reported daily injection in the past month. As for non-injection drug use, about half of respondents had used each of methamphetamine, cocaine, and crack, and more than 80% of participants reported substance use before or during sex.

There was seemingly good access among the survey population to at least basic harm reduction services, with the large majority (> 90%) having made use of a needle and syringe program (NSP) within the past 12 months and having used sterile equipment at last injection (although still 10% reported injecting with a used needle and/or syringe at some point within the previous six months). As for treatment for problematic substance use, 43.6% had accessed opioid agonist therapy within the past 12 months, while one-quarter had used other treatment services for drug or alcohol use.

However, a recent national workshop (focused on the response to methamphetamine and other stimulants) highlighted that access to treatment for Indigenous people on reserves and in isolated communities is poor, in part because of stigma and lack of funding.[202] Other barriers to health services are of concern, too. Nearly half of the Indigenous participants had avoided healthcare services within the previous 12 months. Among those who had never tested for HIV, one-quarter avoided getting tested because of stigma and discrimination (which included fear of negative legal consequences). Barriers to health care for Indigenous GBT2Q people, including those who use drugs, encompass the deep stigma surrounding drug use, the racism they often encounter in non-Indigenous health care settings,[203] and also homophobia and/or transphobia from within their own Indigenous community and from Indigenous service providers.[204] Concerns about confidentiality in health care can be accentuated in smaller communities for 2SLGBTQ+ people, where it may also be harder to find affirming health care from 2SLGBTQ+-knowledgeable providers.[205] Among 2SLGBTQ+ Indigenous people, a significant percentage report experiencing discrimination in their home Indigenous communities and migrating to larger urban centres, but dealing there with high levels of poverty and encountering racism, including within LGTBQ communities and social services.[206] Others have also reported not being welcome as Two-Spirit people within Indigenous health services[207] and, in a recent national study, a high proportion 80%) of trans, Two-Spirit, and non-binary

Indigenous people report challenges accessing or participating in traditional ceremonies,[208] despite this (re)connection with culture being important to many, including Two-Spirit people who use drugs.[209]

An additional challenge is a complicated relationship to harm reduction within some Indigenous communities and organizations — including a perceived incompatibility with Indigenous culture(s) in some cases. However, a growing body of commentary and resources has sought to address this, outlining the ways in which harm reduction philosophy and practice connects to and reflects various principles and teachings that are common to many Indigenous Peoples,[210] and is also part of acting on the calls for action from the TRCC and the MMIWG inquiry.[211]

While it is essential for practitioners to consider how experiences of historical trauma intersect with stressors commonly associated with sexual and gender nonconforming status,[212] it is equally important to guard against a simplistic over-emphasis on socio-behavioural deficits, which risks negatively constructing Indigenous identity in a manner that reinforces stigma, skewing services to address what are seen only as individual deficits,[213] and obscuring the structural factors that are at play, including colonization. In addition to recognizing this structural context, the literature emphasizes the importance of a "strengths-based approach" to promoting health, which underscores "the capacity to achieve wellness despite adversity."[214] In their recent review of the literature, Brennan and colleagues observe that: "Indigenous peoples experience resiliency that is grounded in cultural assets, extending beyond the individual to also include a focus on social, cultural and community assets."[215] In talking circles recently convened by 2-Spirited People of the 1st Nations to discuss how to strengthen the response to opioid overdoses, participants underscored the importance of funding Indigenous harm reduction initiatives directly, and made the following point: "[I]n order to receive funding Indigenous organizations are always having to 'mine their traumas', meaning they have to discuss everything that is going wrong within their communities, instead of being able to discuss the wonderful and resilient work their community has been and is doing."[216] Adopting a strengths-based approach has been specifically urged in relation to addressing substance use issues among Indigenous people and[217] is seen as central to promoting the health of Two-Spirit people.[218]

Indigenous harm reduction is not just needles and naloxone. It addresses the consequences of colonization. It connects people to community, culture, and ceremony.

The Canadian literature in relation to substance use among **African, Caribbean, and Black (ACB) GBT2Q people** remains "strikingly limited," as it was at the time of a 2006 review.[219] However, some key themes emerge from studies in the US and the UK (to be interpreted with appropriate caveats about different contexts), which also accord with observations from key informants and other Canadian sources. These include: the greater role of religious institutions as sources of homophobia and stigmatization surrounding drug use;[220] the dual

challenge of homophobia within ACB communities and racism (including sexual racism) within gay communities, and a corresponding sense of social isolation; self-distancing from a gay or bisexual identity, and the related association of some substances (e.g. crystal meth) with gay sex (in contradistinction to e.g. cannabis);[221] and additional "minority stress," related to substance use, that arises from structural inequalities in access to healthcare, employment, and income, as well as greater involvement with the criminal legal system.[222] There are variations correlated with race/ethnicity in both patterns of substance use observed in some US studies — e.g. that African-American/Black MSM overall are less likely to use substances compared to white MSM (although those who have sex with both men and women report *more frequent* use of certain substances), and, more specifically, white MSM are more likely to use methamphetamine (and to report recent use) compared to MSM of colour.[223] There are also differences when it comes to engagement with, and successful outcomes of, treatment for substance use disorder — although a recent analysis suggests socio-economic status may have a greater effect in explaining these worse treatment outcomes, and has underscored the importance of studying how baseline differences, including on the basis of race and ethnicity, in the social determinants of health affect outcomes related to substance use.[224]

> *Stigma is the biggest part. There are some things we don't discuss in ACB communities, including drugs and harm reduction. The only discussion in many quarters is about abstinence, and this is underpinned by religious beliefs and the demonizing of drugs.*
> — Colin Johnson, Toronto Harm Reduction Alliance

At a series of meetings over the past dozen years, Black gay men in Ontario have identified the need for the following: challenging stigma surrounding substance use; greater conversation among Black gay men about substance use; harm reduction messaging that goes beyond just abstinence; service providers who are more culturally competent to serve Black gay men dealing with substance use; and a wider range of services related to supporting abstinence, decreased use, and safer use.[225]

There is no Canadian data regarding substance use issues among **GBT2Q people with various kinds of disability**, although obviously the dual barriers of homophobia and ableism complicate access to information and health services. There is extensive evidence that people with a serious mental health disorder are at higher risk of also developing substance use disorder, and the prevalence of each, and of their co-occurrence, is higher among GBMSM (which is also associated with an increased risk of experiencing homelessness).[226] GBT2Q people with physical disabilities also face additional challenges. For example, at the CBRC Summit 2019, Szeto highlighted the multiple barriers faced by deaf 2SLGBTQ+ in accessing health information and services, including in relation to mental health and substance use needs, and offered practical tips for service providers to increase accessibility for deaf people (e.g. the use of queer-friendly sign language interpreters; being attentive to client preference in choice

of interpreter, not least because of concerns when discussing what may be sensitive personal information such as sex and drug use; the use of accessibility apps such as those that do live captioning of conversation).[227]

In the case of **young GBT2Q people**,[228] the association between sexual minority status and higher substance use — and hence risk of problematic use — during adolescence has been well documented, including in Canada[229] (as has the positive effect of LGBTQ+-supportive communities, which is protective against such outcomes).[230] Unsurprisingly, high prevalence of substance use also translates into higher risk of harms, including HIV, among young GBT2Q people. In a recent study, young GBMSM in Vancouver also reported growing apprehension about the risk of overdose in the context of a toxic unregulated drug market, adding to the data supporting the researchers' conclusion that: "Equity-oriented policies and programming that can facilitate opportunities for safer substance use among young sexual minority men are critically needed, including community- and peer-led initiatives, access to low-barrier harm reduction services within commonly frequented social spaces (e.g. Pride, night clubs, bathhouses), nonjudgmental and inclusive substance use-related health services, the decriminalization of drug use, and the provision of a safe drug supply."[231]

As for **GBT2Q sex workers**, there is some, albeit insufficient, data on trans women who do sex work. But even less studied and visible is the minority of sex workers who are men, and what specific health challenges and needs they may face,[232] including in the case of those who use drugs. The available Canadian (and international) data suggest that the proportion of sex workers who are men is higher than commonly perceived; that there is considerable variation of sexual and gender identities among men and trans sex workers;[233] and that a significant minority of GBMSM, cisgender and transgender, have engaged in what they recognize as sex work or other transactional sex.[234] The available evidence consistently shows both substance use and HIV as health concerns for male sex workers, including an association in some studies between escort work and methamphetamine use among GBMSM,[235] as well as identifying the role that substance use may play for some in contributing to risk of HIV or other STBBIs.[236] Recent Canadian studies support this concern,[237] including data gathered from male sex workers by a number of GBT2Q health organizations, although it should be noted that it does not show a prevalence of substance use that is dramatically different from that observed among GBMSM as a whole.[238]

"Too often, sex work and drugs are automatically linked in people's minds.… Some sex workers do use drugs, just like some accountants and lawyers, but not all of us do. And for those of us who do, it's not necessarily a problem in our work or personal lives. ... There are definitely sex workers who party when they are working, but there are lots out there who don't."[239]

What is clear is the harm done to the mental and physical health of GBT2Q sex workers by the stigmatization and criminalization of sex work and drugs,[240] including by increasing exposure to violence and impeding their access to services,[241] including harm reduction services.[242] Researchers have also called for structural interventions that would increase housing stability among GBMSM who engage in transactional sex, as well as harm reduction interventions that will speak to specific needs of GBMSM who sell sex — including interventions that support those who do street-based sex work as well as those that involve engaging online, where much of this work is organized.[243]

Canadian data on both **poverty and homelessness** among 2SLGBTQ+ people, and specific correlations between these factors and problematic substance use among 2SLGBTQ+ people, is limited.[244] So, too, is data from other settings such as the US, although it suggests a link, among MSM, between use of criminalized substances and homelessness or marginal housing,[245] and also confirms both of these as outcomes of homophobic victimization.[246] The available data indicates associations between LGBT identity and lower income, as well as an association, among GBT2Q people, between problematic substance use and lower income.[247] Homelessness can result from problematic substance use for some, and can also exacerbate that use.

Homophobia and transphobia contribute significantly to 2SLGTBTQ+ people being heavily overrepresented among *youth* experiencing homelessness.[248] Queer youth have higher prevalence and more varied substance use than heterosexual youth; queer youth experiencing homelessness are also more likely to report problematic substance use than queer youth who are housed; substance use is associated with continued homelessness into adulthood; and queer youth experiencing homelessness need both queer-specific services (including housing) and mainstream services that provide an inclusive and safe environment.[249]

The limited data on the prevalence of homelessness among 2SLGBTQ+ *adults* in Canada shows a higher proportion of 2SLGBTQ+ households "in core housing need," and that sexual minorities are at greater risk of homelessness and experience "hidden homelessness" at much higher levels than heterosexuals,[250] while transgender and non-binary individuals are also overrepresented in populations experiencing homelessness.[251] A 2017 review noted the associations in the literature between internalized homophobia, "substance abuse," and becoming homeless, concluding that the available data "demonstrate that homeless LGBTQ adults have unique physical and mental health challenges, largely concerning HIV and substance use" and that "[w]hat little research does exist highlights that LGBTQ adults who experience homelessness are at greater risk for HIV and mental health and substance use challenges."[252] This association is borne out in more recent Canadian data from Vancouver,[253] while data from Manitoba indicates high prevalence of both substance use and of experiencing homelessness and low income among 2SGBQ+ men (especially among First Nations men),[254] and a more recent review confirmed substance use is among the factors associated with homelessness among LGBTQ+ people.[255] There are few studies into interventions to promote the health of LGBTQ+ people experiencing homelessness who use substances (one among trans women, the other among GBMSM who use stimulants); both showed positive but modest results.[256]

In most settings, including Canada, people who use drugs experience a high burden of **arrest and incarceration** and a high proportion of those incarcerated are there for drug-related offences.[257] The available data confirms that among people imprisoned in Canada, a very high percentage report previous substance use.[258] Black and Indigenous people are significantly over-represented among those imprisoned in Canada.[259] Reliably measuring the extent to which sexual and gender minorities experience arrest and incarceration, and the relationship between these experiences and substance use, is challenging for various reasons.[260] Until recently, there has been no data on the prevalence of incarceration among *sexual* minority populations in Canada, and the very limited data on incarceration among *gender* minority populations showed a substantially higher prevalence of incarceration among trans people than among the general population.[261] A study among trans Ontarians found that 6% reported having been incarcerated previously (compared to 0.4% of the general population), with Indigenous people over-represented among those trans people with this experience, consistent with the significant overrepresentation of Indigenous people generally in prison populations in Canada.[262] In 2022, Correctional Service Canada (CSC) published its first study with a profile of gender-diverse people in Canada's federal prisons,[263] but has no data regarding the sexual orientation of those incarcerated in federal prisons.[264]

The only other Canadian study to date was published in early 2023, based on data from nearly 9000 participants in CBRC's *Sex Now* national surveys in 2018 and 2019.[265] The researchers found that 3.7% of cisgender (non-Two-Spirit) men, 5.7% of trans participants, 10.6% of non-binary participants, and nearly 20% of Two-Spirit participants reported having been incarcerated at some point, figures that are all much higher than the prevalence of incarceration among the general population in Canada. For non-binary and Two-Spirit participants, either ever having injected drugs or having used substances (other than alcohol, cannabis, or tobacco) in the past six months were each associated with a greater likelihood of having also been incarcerated. For trans participants, having been diagnosed with HCV or HIV was linked with higher odds of incarceration. The researchers note other Canadian research in the general population has linked incarceration to higher rates of syringe-sharing and HIV/HCV risk,[266] resumption of stimulant and opioid use, overdose-related deaths, and less use of methadone and community-based health services. They conclude that: "Given that sexual and gender minority people already face additional stigma- and discrimination-related barriers to accessing harm reduction services outside of carceral settings…, our results highlight the need for gender-sensitive prevention, screening, treatment and harm reduction programs in correctional facilities and upon release to prevent HCV and HIV transmission, overdoses, and other potential substance-use related harms."[267] Comprehensive harm reduction services in all Canada's prisons — including, e.g. easy, confidential access to sterile injection equipment — is supported by ample previous research,[268] and by domestic medical and public health experts, human rights bodies, and the federal Correctional Investigator, as well as being recommended by UN agencies.[269] It has not yet been realized — and in fact, in some provincial prison systems, even access to condoms and other safer sex materials is limited.

Interventions

Substance use–related interventions

Broadly understood, reducing the harms associated with problematic substance use among GBT2Q people can and should encompass interventions aimed at (i) supporting reduction of use and abstinence from use, for those for whom this is the goal; and (ii) reducing harms associated with continued use. (In addition, service providers must contend with, and policymakers should act to reduce, the harms arising from punitive drug policies.) In the case of *sexualized* drug use among GBT2Q people, both substance use–related and sex-related interventions are needed, the latter discussed further below.

Reducing or abstaining from drug use

In a recent scoping review of the literature regarding interventions to address problematic drug use among LGBTQ+ populations, Kidd and colleagues found that research into substance use interventions among sexual and gender minority people "is in its infancy"; of the limited number of articles, the majority focused on GBMSM and on psychotherapies for the use of alcohol, tobacco, or methamphetamine.[270]

In the case of opioids, opioid agonist therapy (OAT) is a well-established, evidence-based pharmaceutical option for use in the treatment of "opioid use disorder" (OUD), thereby also reducing the risk of some harms of use (e.g. injection-related risks such as HIV and HCV, as well as overdose/poisoning from illegal unregulated supply).[271] However, as noted in a 2018 review, there is still limited literature specifically about treatment of OUD among LGBTQ+ people, although evidence-informed recommendations have been made. These include (i) integrating OUD care with other behavioural health and primary care services, and (ii) adopting an approach to treatment that actively resists homophobia/transphobia in that it recognizes "the dual stigma of addiction and LGBTQ minority status," challenges structural stigma against LGBTQ people, and taps into the strengths and resilience of LGBTQ people and communities.[272]

Unlike the situation with opioids, there is little in the way of evidence-based pharmacotherapy for problematic stimulant use.[273] While a few medications may show some potential efficacy, the quality of the evidence base is low and further research is needed;[274] there are no medications approved by the regulator in either the US or Canada for stimulant use disorder or withdrawal.[275] In the context of an ongoing crisis of drug poisoning deaths related to a toxic illegal drug market, and hence growing and urgent calls for access to "safe supply,"[276] the BC Centre on Substance Use (BCCSU) has provided practice guidance regarding prescription of certain stimulant medications as a "risk mitigation" measure to help individuals reduce their reliance on the illicit drug supply, for those who do not wish to pursue evidence-based psychosocial treatment or who, despite such treatment, continue to use stimulants and are therefore at high risk.[277]

Psychosocial therapies represent the current standard of care for stimulant use disorder.[278] In 2020, AshaRani and colleagues published a systematic review of non-pharmacological interventions for methamphetamine use disorder, concluding that various behavioural interventions were shown to have positive effects in promoting

abstinence, reducing use or reducing cravings; *contingency management* interventions showed the strongest evidence, but *cognitive behavioural therapy* also showed efficacy.[279] Some other researchers have been less encouraged by the evidence: the same year, Ronsley and colleagues published their "systematic review of reviews" regarding treatment of stimulant use disorder. They concluded that there was sufficient evidence only for the efficacy of contingency management programs, and insufficient evidence to either support or discount the use of various other interventions (including various pharmacotherapies).[280]

As for interventions addressing substance use (and sexual risk) among GBMSM specifically, in 2019, Knight and colleagues published a systematic review of (English-language) peer-reviewed and grey literature (up until October 2017) regarding interventions to address substance use and sexual risk among GBMSM who use methamphetamine. They found that while psychosocial interventions tend to hold more promise than the limited efficacy of pharmacological interventions, the overall quality of the data is moderate, and it is difficult to compare study outcomes given varying study designs. They urged further development of interventions to address both drug- and sexual health–related outcomes among GBMSM who use methamphetamine.[281] Subsequent to this review, additional reports have appeared in the literature, suggesting modest positive outcomes from some a variety of psychosocial interventions addressed specifically to GBMSM (including some reaching men living with HIV specifically).[282]

It has been widely recognized that effective HIV prevention and treatment among GBMSM requires addressing other psychosocial challenges among GBMSM (e.g. substance use, violence, etc.) that interact with HIV, and with each other, to create a combined greater impact on the health of a person or community. Informed by such "syndemic" theory, in 2020, Pantalone and colleagues reported on the results of a systematic review and meta-analysis of trials of "combination behavioural interventions" among sexual minority men that sought to simultaneously address both HIV-related behaviours and other syndemic factors, such as substance use.[283] Specifically with respect to the outcomes of interventions that addressed drug use, there were mixed results. While the heterogeneity of the interventions studied made it challenging to draw general conclusions, they suggested that interventions of "greater intensity" — i.e. more frequent and lasting longer — are likely to produce better outcomes, as are interventions that are culturally tailored for sexual minority men. In addition, they recommended that interventions seek to address not only factors at the level of the individual, but also other factors such as the behaviour of service providers and structural factors (e.g. housing) that affect the health of stigmatized populations such as sexual minority men. According to a subsequent scoping review published in 2022 by Kidd and colleagues, the available data suggest that, when looking at various modalities for psychosocial interventions, tailoring those interventions for GBMSM improves their effectiveness.[284]

Reducing harms while using drugs

For those who use drugs, interventions needed to reduce harms sometimes associated with such use, such as HIV, other STBBIs, and overdose, are well known. Albeit never with sufficient scale and funding, some such services have been implemented for years in Canada, such as *safer injection education* and *sterile needle/syringe distribution*, later expanded to include *distribution of safer inhalation supplies*. Other interventions are of more recent vintage and remain contested and vulnerable to changing political circumstances, such as *supervised*

consumption services (SCS), also known in some instances as *overdose prevention sites* (usually in a lower-threshold set-up).[285] Even some medical interventions with decades of evidence to substantiate them, such as *opioid agonist treatment* with methadone and buprenorphine, still face opposition in some quarters.[286] In the face of an increasingly toxic illegal drug market, *drug checking* services and tools (e.g. FTIR spectrometry, fentanyl and benzodiazepine test strips) have increasingly been implemented, albeit again with insufficient funding.[287]

At least with respect to opioids, concern about the contaminated market has also led to the expansion of OAT in some settings to broader *safe supply programs* — i.e. the provision of a legal, regulated supply of drugs with mind/body altering properties that are otherwise only accessible illegally[288] — as an upstream harm reduction intervention. This has also provoked substantial political opposition from some quarters. As of 2022, safe supply programs (SSPs) were being piloted in 11 sites in three provinces. Among the documented benefits of such programs has been the sense of community and connection experienced by participants,[289] even as implementation has occurred mostly in fairly restricted medicalized models and with challenges.[290] It is worth noting that a less medicalized, more accessible model proposed by the Drug User Liberation Front in Vancouver was rejected in July 2022 by the federal government: Health Canada refused to grant an exemption to allow such a program to operate without risk of criminal prosecution.[291] Meanwhile, alongside small-scale projects offering a legally authorized, quality-controlled supply of otherwise illegal substances, a body of research demonstrates the existing reality of people using *cannabis for harm reduction*, including as a substitute for stimulants and opioids, to treat withdrawal, or to come down off other drugs — and this practice has been documented as more likely among people who reported difficulty accessing addiction treatment or who used drugs for which effective treatments are limited, such as methamphetamine.[292]

Sex-related interventions

As discussed above, both the literature and the key informants identify the strong connection for some GBT2Q people between the use of substances and their sexual lives and practices. Given this, addressing problematic use will often implicate at least a discussion of sexuality and, in the case of those who engage in problematic chemsex, will necessarily involve changing not only substance use behaviour but also sexual behaviour, another domain of life that implicates strong psychological and physiological impulses. Several key informants noted this important point about the connection between sex and substances, which must be addressed if harm reduction or other interventions are to be effective.

> *Harm reduction needs to encompass not just drug-related harms but sex-related harms. We cannot just deal with the drugs part or the sex part; they are combined.*
> — Colin Johnson, Toronto Harm Reduction Alliance

All of the elements of substance use–related harm reduction described above are of relevance generally to GBT2Q people who use drugs. Most of them are also applicable in the context of sexualized drug use, including chemsex/PnP, although some would require adaptation — e.g. operation of a supervised consumption space in a sex-on-premises venue such as a bathhouse.[293] Obviously, in the context of sexualized drug use, also relevant are long-standing sex-related harm reduction interventions aimed at reducing risk of HIV or other STBBIs, such as condom use and the use of ARVs for HIV prevention (as treatment to achieve viral suppression among men living with HIV, and as pre- and post-exposure prophylaxis among HIV-negative men). The combination of substances and sexual activity necessarily requires the combination of these two dimensions of harm reduction. This is, unsurprisingly, reflected in individual practice. For example, as Gaudette and colleagues have reported, GBT2Q people in Quebec who engage in chemsex identify many individual strategies for minimizing harms, including learning about the substances being used, avoiding combining substances, using sterile equipment, and using in safe spaces, as well as discussing substances and sexual practices with partners to ensure consent, and providing direct assistance to those in need.[294]

This also points to the need for integration of service provision. One need frequently mentioned by key informants was for substance use-related services to be integrated with other mental health services and with sexual health services, particularly in cases where someone is seeking support in relation to chemsex/PnP. Most spoke of the need for a full range of "wrap-around" supports, including forms of peer support. Support in addressing housing and income needs is also important (see point below).

> *[It's really important that we] be able to offer integrated services. For example, a big part of the counselling for people who PnP is a reappropriation of their sexuality. People need access to substance use counselling that is integrated with sex therapy.*
> — Mathieu Mailhot-Gagnon, RÉZO (Montreal)

Such integration has also been recommended by researchers such as Knight and colleagues: in their review of interventions to address methamphetamine use among GBMSM, they underscored that, given the prevalence of *sexualized* use of methamphetamine among GBMSM, "disregarding sexual health risk in [methamphetamine] interventions and research is a missed opportunity." Given the nexus between sexuality and substance use for a significant number of GBTQ men and other sexual and gender minority people, they conclude their review "provides compelling evidence" for integrating interventions to reduce both drug- and sexual-related harms (e.g. distributing harm reduction kits for safer substance use via sexual health care settings). Subsequent research in Vancouver has shown such integration would be welcomed by service users.[295] In its updated consolidated guidelines on HIV prevention among key populations, WHO includes "addressing chemsex" as a "good practice" forming part of essential health interventions, noting this can include integrated services for sexual and reproductive health, mental health, access to sterile injection equipment and OAT.[296]

For people who engage in sexualized drug use, effective harm reduction must also address sexual health–related harms, including measures to prevent HIV and other STBBIs, such as access to safer sex materials and universal access to pharmacological interventions such as PrEP and PEP. Integrating harm reduction services and outreach into sexual health care settings is also key.

Need for additional research and interventions

The range of tools in the harm reduction toolbox, and knowledge of how best to use them, needs to be strengthened. In particular, given the central role that stimulants play in drug use among GBT2Q people, particularly in the context of chemsex, there is a need for substantial and sustained investment to develop effective psychosocial and pharmaceutical interventions for *preventing and treating* problematic stimulant use, as well as investment in scaling up comprehensive *harm reduction* approaches.[297] These include the interventions identified above, but because the phenomenon of stimulant overdose is less well defined and understood, harm reduction efforts also need to include increased overdose education so that users (and service providers) can better identify the signs of stimulant overdosing and be better equipped to respond so as to minimize harm.[298]

There is also a need for more *implementation research* to guide the design and delivery of harm reduction interventions in relation to stimulant use and in relation to the drug use patterns and practices of GBT2Q people. In a US study, Wilkerson and colleagues were able to determine differences between different sub-categories of MSM who use methamphetamine for PnP as to which substance use–related and sexual behaviour–related strategies they used to reduce risk of harm, and to correlate this with demographic information and the degree to which men were "out" as GBMSM. They suggest this could be helpful in tailoring intervention messages about different harm reduction strategies for certain groups and in communicating those messages.[299] Researchers in Canada have noted that there is a "need for implementation research to determine best practices to address the high levels of discrimination, poor mental health and substance use harms that gbMSM experience."[300] As Knight and colleagues concluded, the dearth of published studies of *harm reduction* interventions — as opposed to interventions primarily focused on treatment of "substance use disorder"— among GBMSM who use methamphetamine "is worrisome — particularly in a medical context where there is currently no 'gold standard' in MA [methamphetamine] use treatment,"[301] and more research is needed to assess harm reduction interventions such as syringe exchanges, drug checking, nutritional supplements, clean pipe kits, etc. in this population. It should be noted that, specifically with respect to methamphetamine, as of early 2022, it appears that there had not yet been any randomized controlled trials of harm reduction interventions in relation to methamphetamine use.[302]

Other evidence confirms additional barriers to harm reduction practice. For example, in the 2018 Edmonton 2SLGBTQ+ substance use survey, of those who reported using substances in the past 12 months, the large majority (80%) indicated knowing where to get a naloxone kit, but only one-quarter (24%) indicated they had one. Only one-third (34%) of respondents reported knowing where to get a drug testing kit or strips, and only 13% reported actually having these. Most recently, Chayama and colleagues have reported on the first study in Canada to gather data from sexual and gender minority (SGM) men regarding drug checking services. Among this sample of young SGM men, all of whom reported using substances for sex within the past year, there was limited awareness and experience with drug checking services, but strong interest in accessing them as a harm reduction measure. They identified social (e.g. anti-drug stigma), structural (e.g. drug criminalization), and spatial (e.g. lack of services outside of downtown Vancouver) barriers in the current context of drug checking services and supported greater access to such services in GBT2Q community settings.[303] In short, there is a need and there is a will for harm reduction among GBT2Q people, including those who engage in sexualized drug use, but work to be done to expand the range of interventions and to strengthen both access to and the uptake of those interventions.

Barriers to services for GBT2Q people who use drugs

Insufficiency of services

As a general matter, Health Canada has recognized that "only a small fraction of people in Canada who seek treatment for problematic substance use are able to access it when they need it… Part of the challenge is that treatment options are not always available when and where Canadians need them, partly driven by insufficient numbers of health professionals with the appropriate training in substance use issues."[304] This was reiterated in the public consultation held in 2018 to solicit input regarding strengthening Canada's response to substance use issues in the next phase of the *Canadian Drugs and Substances Strategy*.[305] It is against this backdrop of insufficient services overall that GBT2Q people who use drugs face additional challenges in accessing care and support.[306]

Scheim and colleagues have reported that GBMSM in Vancouver who inject drugs have a lower likelihood of accessing addiction treatment.[307] In Edmonton, the Queer and Trans Health Collective reported that, among respondents to its 2018 survey of 2SLGBTQ+ people who use substances, between 30% and 76% of people reported sharing equipment with others — and yet only three individuals reported accessing harm reduction or safe consumption supplies.[308] In 2019, Salway and colleagues reported results from a survey of STI clinic users in the Vancouver area, two-thirds of whom identified as sexual minorities: 10% reported a recent need for care related to substance use, and of these, more than three-quarters had not met with a care provider about this need. A greater proportion of gender minorities, sexual minorities, and those attending suburban STI clinics reported barriers to accessing services for mental health or substance use concerns, compared to cisgender, heterosexual, and urban comparators.[309] Arthur and colleagues analyzed data from both CBRC's 2019 *Sex Now* Survey and an online survey (part of the "CrystalMethamphetamine Project") that specifically surveyed more than 200

GBT2Q people in the Vancouver area who had used methamphetamine in the past six months. When asked how easy it was to get help for their substance use, nearly one-quarter of respondents replied “not at all easy” and more than another one-third replied “only a little.” Nearly one-third were not confident that they would be able to get help, 70% had not used services providing safer injection materials within the past six months, and less than half had ever received treatment, counselling, or harm reduction services.[310] Gaudette and colleagues reported, from in-depth interviews with men and non-binary people in Quebec who engage in chemsex, that waiting lists and the dearth of resources in certain regions, especially outside urban centres, are barriers.[311]

The most recent national data come from CBRC’s 2021 *Sex Now* survey: while just over half of the respondents were not actively seeking to change their substance use, almost one-third (31%) wanted to reduce or quit their use. However, about one in 10 people who used crystal meth (11%) and people who injected drugs (12%) reported facing barriers in access to services. Meanwhile, a high percentage of people who use opioids (17%) reported a need for naloxone kits, and the need for harm reduction supplies was reported by a quarter (26%) of people who use crystal meth and half (49%) of those who reported injecting any substance.[312]

Cost of services

Cost is a significant barrier. As Health Canada has recognized, private “addiction treatment” providers in Canada are not regulated and the quality of service varies, with a lack of minimum standards and consumer protection.[313] (Certain health care professionals working in such private settings are subject to their professional regulatory standards, where these exist.) Furthermore, the cost of such private services makes them inaccessible to many, particularly those most marginalized and at risk.[314]

As for data regarding GBT2Q people and their access to services, Salway and colleagues reported in 2019 that, among service users of sexual health clinics in Vancouver (two-thirds of whom were sexual minorities), one-quarter of those who reported a recent need for care related to mental health or substance use indicated they couldn’t afford the service.[315] Similarly, Ferlatte and colleagues also examined barriers to mental health services among SGM people: from an online survey of nearly 2800 SGM people, inability to pay was the most frequently cited barrier, mentioned by nearly two-thirds of respondents.[316] As Gaspar and colleagues reported in their 2019 qualitative study among sexual minority men in Toronto regarding their experiences in accessing mental health care (including for substance use), the most common barrier cited was that services were unaffordable.[317] The national study by Card and colleagues, as well as research specifically in BC and in Quebec, confirms that among GBT2Q people who use methamphetamine (including in the context of chemsex), cost of access to therapy not covered by public health insurance systems is a barrier to access. [318]

Stigma

GBT2Q people who use drugs face at least two kinds of stigma — in relation to their substance use and in relation to their sexual and/or gender minority status — in accessing at least some kinds of services, depending on the setting and provider.[319] Some GBT2Q people may face additional kinds of stigma depending on such factors as

race, engaging in sex work, etc. As Kidd et al. have summarized the research, "sexual and gender minority" (SGM) populations face providers' negative or ambivalent views about SGM patients; and relatedly, concern about potential negative experiences in *treatment*, such as providers' bias and the safety of disclosing one's sexual or gender identity. It is therefore not surprising that SGM individuals report lower satisfaction with treatment compared to heterosexuals.[320] For trans people, there is a broader problem of access to care generally. Research in Ontario has found that more than half of trans people reported negative experiences when presenting in their felt gender in hospital emergency departments, and one in five reported having avoided emergency care at some point because they expected that they would experience negative treatment as a result of their gender identity.[321] Additional data from Ontario reported in 2017 showed that transgender people are a medically underserved population, with barriers ranging from lack of provider knowledge on trans issues to refusal of care.[322]

Stigma surrounding substance use

The stigma surrounding drug use, particularly problematic use and particularly certain substances, is deeply entrenched — and reinforced by the criminalization of (certain) drugs and of people who use them. It also operates as a significant barrier to services.[323] Canadian data suggests stigma related to substance use operates as a significant barrier to care among GBT2Q people who use drugs. For example, Salway and colleagues have reported that, from their survey of service-users at sexual health clinics in Vancouver (two-thirds of whom were sexual minorities), of those who reported a recent need for care related to mental health or substance use, one-quarter identified shame as a barrier that had kept them from accessing care.[324] Among 2SLGBTQ+ people in Edmonton who use drugs, stigma and discrimination featured prominently as reasons respondents delayed access to substance use support, tools, or services: 31% identified concerns about stigma and discrimination against people who use drugs, 24% expressed a general concern about service providers being judgmental, and 15% raised concerns about discrimination against 2SLGBTQ+ people.[325]

Stigma related to sexualized drug use

Furthermore, as has been highlighted in the literature, and repeatedly by all the key informants consulted for this project, given the *stigma surrounding sexualized drug use*, it becomes even more challenging to find a service provider who is knowledgeable and equipped provide non-stigmatizing services in particular to SGMSM who engage in chemsex.

In the Greater Vancouver area, consultations with GBT2Q people who use(d) crystal meth and with service providers have highlighted that "the stigma associated with general and sexualized crystal meth use was commonly reported as a barrier to service access among peers and providers, especially when this intersected with stigma related to HIV and GBT2Q identities."[326] Among those who had a regular healthcare provider, while more than 90% were out to their provider about their sexual orientation, only 54% had disclosed their use of crystal meth use to their provider; only 61% were "very" or "somewhat" confident that they could disclose this to their provider. In Quebec, in-depth interviews with 64 sexually diverse men and non-binary people indicated that participants anticipate stigmatization with regard to their methamphetamine use and the associated sexual

practices, and, more generally, their sexual orientation, which constitutes a barrier to service accessibility.[327] Reflecting on their experiences with service providers, participants also identified a range of positive and negative responses, the latter including alarmist and stigmatizing commentary about methamphetamine and chemsex.[328] Among participants in a BC project interviewing GBMSM who use crystal methamphetamine, only 60% were confident that they could disclose their use to their doctor, and just under half were confident that they would be able to find a program for support regarding their use where they are comfortable. Furthermore, two-thirds had never received any treatment, counselling, or harm reduction services.[329]

> *"Substance use for LGBT people is often enmeshed in issues relating to sexual orientation, gender identity, and/or making connections with queer people and communities. It is not possible for LGBT people to successfully address alcohol and drug issues without dealing with issues relating to sexual orientation and gender identity. LGBT people are not able to bring forward the whole of their experiences when they are in environments that are non-supportive and where they experience homophobia or transphobia."* [330]

Key informants were unanimous in highlighting stigma — and its enactment through discriminatory policies and practices — as among the most significant challenges to overcome in protecting and promoting the health of GBT2Q people who use drugs, and observed that multiple, often intersecting, kinds of stigma were at issue. Stigma surrounding gay sex, and the homophobia and discomfort discussing gay sex — let alone gay sex in combination with drugs — that people experience in their encounters with some service providers, impede access to services. Shaming those who have multiple sexual partners, including in the context of sexualized drug use, compounds the situation for GBMSM generally and particularly for those who do sex work. Additional kinds of stigma and discrimination, such as structural racism, transphobia, and ableism, can not only create additional risk of substance use becoming problematic but impede access to services needed. The role of conservative religious or other cultural norms in creating and deepening stigma, especially in relation to sex(uality) and substance use, cannot be ignored, and can be even more pronounced in some communities.

It's all kinds of stigma at work — about sex, sexuality, drugs… Then when you get into particular communities, because of the historical relation to drugs, there is a whole other layer of stigma that can come along with it. Some will feel like you're letting your community down. There's the whole tie-in with religion. There's the relationship with the legal system and how some communities have been over-policed… If it's already challenging enough for a middle-class white guy to find services, what about other guys in our community facing these additional layers of stigma?

— Nick Boyce, Canadian Drug Policy Coalition (Ottawa)

Numerous informants also spoke specifically about the heightened stigma attached to specific drugs —crystal methamphetamine in particular — and about specific modes of drug use, i.e. injection. Several informants also spoke about the unsurprising challenge of deeply internalized stigma experienced by many GBT2Q people who experience problematic substance use, which itself is a barrier to even seeking support and attempting to overcome other barriers.

Stigma is one of the biggest barriers relating to queer substance use. Not just stigma regarding substances, but regarding sex and substance use together (PnP), especially with crystal meth. There is a hierarchy of substances and of stigma about meth in particular… Previous anti-drug — and especially anti-meth — publicity campaigns perpetuated negative and often inaccurate views towards substance use, such as the "Dare" campaign and also "The Face of Meth" campaign... that was really harmful!... You see people's faces change when you admit to doing meth, and then the way they treat you changes. There's also a lot of stigma surrounding sex and having a lot of sex as well, slut-shaming.

— Andrew Thomas, AIDS Coalition of Nova Scotia (Halifax)

Stigma emanates not just from service providers but from within 2SLGBTQ+ communities as well, creating a further barrier: as Day points out, "the denial and stigmatisation of men participating in chemsex by their gay peers… created a barrier to accessing services, either with gay men's health services that often [have an...] aversion to drug use, or traditional heteronormative harm reduction services."[331] A number of studies and commentaries have highlighted the stigmatization within gay communities of people who use drugs (and particularly methamphetamine).[332] Key informants unanimously noted the need to tackle stigma related to drug use, including sexualized drug use, within GBT2Q communities. One key informant noted that even among those who PnP, there can be stigma (e.g. against those who inject).

There's stigma within the MSM community but there's also stigma within the chemsex community. For instance, people who smoke crystal might talk about people who inject in a demeaning or judgmental way. I see the damage it causes — this is why people isolate, because they feel their behaviour is unacceptable. They may want to stop using, but at the same time there's such a connection with pleasure, intimacy, sexuality that it's really hard to stop.

— Mathieu Mailhot-Gagnon, RÉZO (Montreal)

The PnP community is both within the wider GBMSM community but apart from it; we stick to ourselves. There is such judgment and shaming of GBMSM who use substances, and in particular PnP, within our own community. If we want to reduce the stigma in our community it will take more people stepping out and sharing their stories. People can identify with the human being telling the story and begin to challenge the simplistic stereotypes that exist.

— Key informant

Interventions needed for GBT2Q people who use drugs

Access to culturally competent services

Given the above, it is not surprising that a key conclusion emerging from the literature, and highlighted by key informants, is the need for health services that are specifically oriented to serving 2SLGBTQ+ people who use drugs. This has been highlighted in particular in relation to GBMSM who struggle with problematic sexualized drug use, and especially with particularly stigmatized substances, such as crystal meth. Numerous Canadian studies are consistent with literature from other jurisdictions in pointing to the need for services specifically equipped to meet the needs of 2SLGBTQ+ people, including GBT2Q people who engaged in sexualized drug use.[333] For example, in a BC project interviewing GBMSM who use crystal methamphetamine, Fulcher and colleagues have reported that participants wanted services tailored to their specific needs and called for making culturally competent adjustments related to sexuality to provide GBMSM-specific treatment: “Given the interrelatedness of sexual activity, sociality, and identity with methamphetamine use among gbMSM…, understanding this population’s experiences with substance use services is critical. Characteristics of treatment programs that may be appropriate for individuals who use substances in general—such as a requirement of abstinence—may be a barrier to care for gbMSM, whose patterns of substance use are often strongly influenced by their sexual and social interactions….”[334] In 2021, highlighting the specific needs of SGMSM who use drugs, Card and colleagues called for: “the creation of one-stop, low-barrier, integrated care that is culturally sensitive and trauma-informed. The need for these services is particularly important given the bifurcation of services tailored for SGMSM (i.e. SGMSM services may not be culturally safe to people who methamphetamine and other services tailored for people who use methamphetamine may not be culturally safe to SGMSM.)”[335]

"This important intersection of sex, sexuality, and drug use is rarely taken into account by addictions or recovery services…. Most programs and organizations don't even know what PnP is… This means that PnP often isn't addressed in mainstream programming, counselling support groups, or in educational materials, which often focus solely on substance use without connecting it to queer sex and sexuality. … This is a huge component of our lives and often a big piece of why we use substances. To go to a support group, for example, and not feel comfortable discussing your sexuality is a huge barrier." [336]

While there is a need for services that are specifically tailored to GBT2Q people, this must be accompanied by efforts to ensure other services are also inclusive, welcoming spaces for GBT2Q people. This echoes observations in the literature: "at a population level, the greatest benefit to MSM who use drugs is likely to emerge from equal access to existing harm reduction services that are attentive to their specific needs and social or cultural circumstance."[337] For example, in the UK, interviews with both GBMSM who PnP (and were not accessing services) and service providers identified the need for the latter to work in partnership with local LGBTQ+ organizations to ensure cultural competence, including in relation to the intersection of sexual and mental health and in addressing the needs of GBMSM who inject drugs associated with chemsex.[338]

Many of the Canadian studies cited above regarding stigma call for efforts to develop the "cultural competence" of service providers to provide informed, non-stigmatizing services to GBT2Q people, including in relation to sexualized drug use. Key informants also spoke of the need to support service providers in becoming properly "culturally competent" in relation to substance use, including sexualized use, among GBT2Q people — including acquiring some basic understanding of, and comfort addressing with service users, the socio-cultural factors affecting substance use by GBT2Q people, norms within GBT2Q communities, and sexual and drug-use practices.

GMSH is offering a CME-accredited course for clinicians — a "PnP 101" intro course designed to inform professionals to adopt a cultural humility approach to working with GBMSM who use substances. I would love to see the mental health sector and the professional schools and colleges step up and commit to doing this kind of training. Be it in the hospital emergency or the therapist's office, safe and unbiased care shouldn't be optional, and it should be a standard part of training for any profession that works with GBMSM. We also need some sort of accountability for ensuring good practice. If you're a drug user often you feel you cannot push back against stigma and poor care so who do you turn to? We need to have systems in place that will hold professionals accountable and empower GBMSM who use substances to stand up for better care.

— Jordan Bond-Gorr, Gay Men's Sexual Health Alliance (Toronto)

Additionally, harm reduction and other service providers need to be supported to acquire the cultural competence to effectively provide services GBT2Q people in all their diversity. This includes developing an understanding of structural inequities based on racism and colonization, as well as sexual or gender minority status. It also means taking an approach in harm reduction practice that seeks to counter these inequities (themselves a key source of harm), while recognizing and reinforcing the strengths and resilience that GBT2Q people have — which is evidenced not only by their survival despite such inequities, but by the steps they take to protect and promote their health, including in the context of their substance use.

> *How do we provide services related to PnP that are adapted to the needs of trans men, trans women, non-binary individuals? I feel there's a gap there. There is some info addressed to trans men in a guide recently released , but I don't know of any other resource like at the moment.… I hope it's possible in the future to create tools adapted to the needs of trans people, but we need to assess what the needs are.*
>
> — Mathieu Mailhot-Gagnon, RÉZO (Montreal)

Key informants who spoke to this issue were also all fully supportive of taking proactive measures to increase this competence of service providers, from "softer" approaches such as making educational resources and opportunities available to setting and enforcing certain standards of good and acceptable practice.

> *Pull all the levers possible, from licensing bodies or schools or professional associations making suggestions, all the way up to enforcing some sort of policy and mandating training. There are enough good people out there who are genuinely interested and want to learn, but sometimes there's also a need for some top-down approaches, saying "you need to do this."*
>
> — Nick Boyce, Canadian Drug Policy Coalition

Queer spaces, peer places and faces

In light of the particular ways in which sexual identity intersect with substance use for many GBT2Q people (including sexual practices in the context of chemsex), and of the multiple stigmas often at play, the literature suggests — and key informants uniformly agreed — that there is a need for services that are offered by and for GBT2Q people. This is related to the observation that there is little access to services that are equipped to provide proper, non-judgmental, culturally competent service to GBT2Q people who use, particularly in relation to sexualized drug use.

> *Mainstream addiction treatment programs have absolutely no understanding of gay men's health issues, how to talk openly about these… We need to build up competence of mainstream service providers, but you can only build up some people's capacity so much if you don't have that lived insight. We need to be ramping up queer service providers to do this work too.*
>
> — Nick Boyce, Canadian Drug Policy Coalition (Ottawa)

Community organizations — including people with personal experience of substance use — are key to identifying and shaping services to respond to priority needs. In addition, as part of building the capacity of 2SLGBTQ+ people and of people who use drugs to support and strengthen their own communities, some key informants also expressly noted the importance of training and hiring people with lived experience to do some of this work:

> *Having community groups at the forefront of being able to distribute harm reduction supplies, test substances and provide supports similar to SCS sites is really priority number one, recognizing that community members are the true experts in their field. Those organizations who hire those with lived experience, and are by and for the community, are those that the government/funders need to support the most.*
>
> —Jess Murray, Queer and Trans Health Collective (Edmonton)

The literature also highlights the importance of ensuring services that are by and for GBT2Q people. For example, in the national survey of 780 men and non-binary people who have sex with men and use methamphetamine (one component of the Crystal Methamphetamine Project), respondents reported the "most important characteristics" in a program addressing meth use as including the following: "the staff understand the role of drugs in my social or sexual life" (84%); "the staff understand the role that drugs have in my mental health" (80%); "the staff have experience using methamphetamine" (i.e. were peers) (73%); "the staff understand the role that drugs have as a part of my identity" (70%); and "the staff identify as LGBTQ2S" (65%).

Among GBMSM who use methamphetamine interviewed in British Columbia in 2018, study participants highlighted the desire to connect and find support from others who could empathize based on personal experience, and "expressed feeling safer and wanting to access services specifically for gbMSM," particularly given fear and/or experience of stigma — related to both sexuality and substance use — in the context of current substance use treatment services. [339] Additional consultations with GBT2Q men in the Greater Vancouver area have identified several key findings regarding the services and supports needed for GBT2Q people who use crystal meth, including (1) the need for GBT2Q-sensitive and -specific programs, and (2) the importance of involving peers (i.e. GBT2Q people with personal experience of substance use) in developing and delivering services.[340] In Quebec, among those GBT2Q people who engage in chemsex interviewed by Gaudette and colleagues, a common theme was that "peer helpers," people who have their own lived experience of chemsex, "have an excellent understanding of the issues and potential repercussions of methamphetamine use in a sexual context."[341]

This includes having staff (and volunteers) who represent the diversity of GBT2Q communities, so that who works, and who is seen as working, in harm reduction (and other) organizations communicates to potential service-users that they are welcome and supported. For example, which faces and voices are seen and heard in outreach materials signals who can expect to feel welcome and supported when seeking services. In the national survey that formed part of the Crystal Methamphetamine Project, not only did participants strongly identify the importance of programs provided by queer people, including those with first-hand knowledge of substance use, but among participants who were not white, 15% stated that having other participants in a support service of the same ethnicity was important, while 29% of the participants who identified as Indigenous rated it important that program staff be Indigenous.[341]

> *Two major concerns come up [for Black people who use drugs]. Do they feel safe in that space? Are you making them feel safe? This includes the language that's used, the looks that [are] used, the body language that is used. And are you sure that what we do with you is not going to come outside, that nobody is going to hear it? Unless people can feel safe and that what they're doing is confidential…it will not work.*
>
> — Colin Johnson, Toronto Harm Reduction Alliance [342]

Several key informants also spoke of the fundamental importance of support services that create the opportunity for connection, including with others who have some similar shared experience. This is particularly important in the case of problematic chemsex: it often attracts an even deeper stigma — including from within the GBT2Q community, and an internalized stigma for some; it can result in a more profound isolation from family, friends and community other than fellow PnP'ers. As a result, breaking patterns of problematic use can be particularly difficult, making support from others with similar experience particularly valuable.

> *When support is coming from someone who has had a similar experience to you, it seems more genuine and there is almost an immediate sense of connection through shared trauma that is established. I can't stress enough how important this is.*
> — Andrew Thomas, AIDS Coalition of Nova Scotia (Halifax)

> *It's really hard to address stigma. One of the ways I've found useful is with group work… Guys I counsel on an individual basis tell me it's eye-opening. Men tell me stuff like: "I see myself as a piece of shit, and then I meet these men [in the group] who don't look like pieces of shit, but who also see themselves the same way; it changes everything about how I see myself now." Even if they think negatively about themselves, there's a switch [in their perception of themselves]; that's why it's so valuable to have such a group.*
> — Mathieu Mailhot-Gagnon, RÉZO (Montreal)

This call for queer spaces, and for the presence of peers — i.e. other GBT2Q people with personal experience of substance use — in various roles, is consistent with a broader well-established literature and practice outlining and demonstrating the case for the meaningful involvement of people who use drugs in all facets of the response to drugs and drug policy, including harm reduction,[344] as well as describing the meaningful roles they can play.[345] Such guidance should be kept in mind as efforts are made to strengthen the harm reduction response to problematic substance use among GBT2Q people, and in a manner that engages peers in various aspects of that response.

Easy access to harm reduction information and supplies

Several key informants made the point that harm reduction services need to address *when, where, and how* GBTQ2 people are using drugs. In particular, having access harm reduction information, supplies, and services in ways that help protect confidentiality is key, given the stigma surrounding drug use and concerns about being identified as GBT2Q if accessing services in a particular location. Outreach of various kinds is key to increase access — including discreet mail-order distribution, mobile distribution sites, dispensing machines, and the possibility of direct delivery. Fixed site, or even mobile but still public, supervised consumption services and needle/syringe programs will not address harms associated with substance use in a sexual context. Recognizing the connection between sex and substance use means that harm reduction practice needs to include making information and supplies accessible where sexualized substance use happens, whether it's in a sex-on-premises venue (e.g. bathhouses/saunas) or in private spaces (e.g. homes, hotel rooms) and when it happens (e.g. including overnight and on weekends).

Taking harm reduction services — including, for example, drug checking — to spaces and events where GBT2Q people gather (e.g. bars, festivals, events) is important to connect with those in need.

Some key informants pointed out that both 2SLGBTQ+ community organizations and businesses that seek or rely upon 2SLGBTQ+ customers should commit to harm reduction to protect the health of GBT2Q people who use drugs. There were mixed reports about the extent to which bars or bathhouses/saunas serving GB2TQ communities were allowing or even proactively engaging in the distribution of harm reduction information — and, beyond that, the distribution actual safer drug use kits, as they do with safer sex supplies. Some key informants reported previous opposition in years past to even the provision of safer drug use information, although this appears to have improved. In some settings, with some establishments, this is now accepted practice, and some also provide "sharps" containers for safe disposal of syringes/needles and other equipment. While some key informants suggested the distribution of harm reduction supplies was happening in some such local venues, others said it was not.

> *We have a mobile FTIR spectrometer that enables us to provide support at a wide range of outreach events throughout Alberta, particularly queer events and festivals where individuals need safer/braver spaces. Within Edmonton, we are providing substance checking support at our office, and we're currently looking into getting a van to meet our participants wherever they are. As with supervised consumption sites, people in the queer community may not feel comfortable or have the ability to access drug testing support at one physical location. So, if we're meeting them for harm reduction supply delivery at their own home, or where they go to party/use substances, we're one step closer to providing them with the support they need.*
>
> — Jess Murray, Queer and Trans Health Collective (Edmonton)

I would love to see bathhouses distributing harm reduction supplies, but I'm not aware of any formal partnerships [between them and community organizations] doing this.
— Key informant

The saunas… provide access to yellow [safe disposal] boxes to throw away used drug injection and other drug use material. They don't provide access to safer drug use material on site and don't allow it. People generally come to our offices to obtain this type of material rather than getting it there.
— Mathieu Mailhot-Gagnon, RÉZO (Montreal)

Full range of services

Several key informants spoke of the need for substance use services for GBT2Q people that are multi-faceted and address the range of factors affecting their substance use and their health more broadly. Some people need support with abstaining from substances. Others need support in reducing their use or modifying when and how they use and, in the case of sexualized use, in reducing risks of harm related to sexual behaviour. Improved access to safe supply would reduce the occurrence of overdoses. Support needs to be available in multiple forms (e.g. groups, one-on-one) and ways (e.g. in-person, online, via phone or chat/text, etc.). For those using drugs, easy access to accurate, non-stigmatizing information and to harm reduction materials (e.g. safer injection or inhalation kits, test strips, naloxone) is key, taking into account when, where, and with whom people use. Most spoke of the need for a full range of "wrap-around" supports, including forms of peer support.

One approach does not fit all, and we need to use as many tools in the toolbox as possible. We should have the entire spectrum of care from abstinence programs to safe supply and harm reduction. We need to include both individual and group counselling services, peer support, outpatient education and therapy (including online), in-patient and residential treatment. There should be options for people who cannot be abstinent to get into programs where they can detox and start care, rather than have to demonstrate a period of sobriety after detox. We should have better drug testing services, including a spectrometer, as people are dying due to contaminated product. More access to vending machines with harm reduction supplies. Safe consumption sites and sharps disposal programs throughout the province.
— Andrew Thomas and Patrick Maubert, AIDS Coalition of Nova Scotia

It would be great to have … a line for people who engage in chemsex that is accessible 24/7, so that if someone comes out of a PnP episode, they can just call and get counselling, or if they get a craving, they can get support.

— Mathieu Mailhot-Gagnon, RÉZO (Montreal)

When I think about guys I know who have accessed services, harm reduction is one thing, but when they need withdrawal, detox, and treatment support, even if they can find something it's rarely culturally relevant, and even if there is some understanding, there's no aftercare. You may end up in a detox program or do a bit of drug treatment, but then you're right back into your community, with no follow-through, little other support, especially in a community where there is such normalized drug use.

— Nick Boyce, Canadian Drug Policy Coalition (Ottawa)

Underlying factors, including social determinants of health for GBT2Q people

Numerous key informants highlighted the importance of adequately addressing, through funding and policies, the various social and individual determinants of health among GBT2Q people. This is consistent with the literature that demonstrates the many ways in which factors such as trauma, bullying, abuse, violence, isolation, and discrimination — including those rooted in systems and practices of colonization, racism, homophobia, biphobia, transphobia, HIV stigma, sexism, etc. — contribute to poorer outcomes with respect to education, income, and ultimately physical and mental health, including problematic substance use and additional challenges in accessing services.

We need a more diverse range of options to support people, across the spectrum of substance use. We could prevent a lot of harm by funding upstream interventions to help people deal with things in life that can turn drug use from recreational and controlled to problematic — things like grief counselling, counselling about job loss, etc. Rock bottom is not a concept we need to take with us.

— Jordan Bond-Gorr, Gay Men's Sexual Health Alliance, Toronto

Basic needs, such as housing and income security, were highlighted by several key informants as essential aspects of preventing, treating, and reducing the harms of problematic substance use among GBT2Q people — as they are among other people, but recognizing that homophobia and transphobia create heightened risk of poverty and homelessness and sometimes additional barriers to accessing, e.g. safe housing and shelter services.

> *We need more social funding. Social programs are critical to bettering the health and happiness of our community. … Many of the clients who've accessed our programs have required much more than solely harm reduction supplies or support around substance use, so a holistic approach looking at all key areas of health and basic human needs must be adopted.*
>
> — Andrew Thomas and Patrick Maubert, AIDS Coalition of Nova Scotia

Securing and sustaining funding

Several key informants spoke about the challenges of sustaining services without sustained funding. This has negative effects on the capacity of the community sector to respond to communities' needs and, ultimately, on the health and wellbeing of GBT2Q people who use drugs. Regularly changing funding programs and priorities is part of the problem.

> *Additionally, there is a lack of stable programming, due in part because of the short-term nature of funding. Funding instability leads to instability in services, and that breaks community trust in our organizations and often further disenfranchises people who are now without support. We cannot force essential programs to justify their existence every 2-5 years. Funding needs to be stable and longer term.*
>
> — Key informant

> *Current funding [from Health Canada] is about to run out, and isn't being renewed, even though we've met and exceeded all the deliverables. We're trying to find some other funding to sustain some of the work on PnP, even if the full program we've built can't continue. At least it would be good if we could continue the "PnP Hangouts" because these are really important for people to develop social connections with other guys who have a similar experience of PnP, because it can be a really isolating experience.*
>
> — Andrew Thomas, AIDS Coalition of Nova Scotia (Halifax)

Another problem is access to funding in the first place, including for truly community-driven responses, as a result of the onerous processes and requirements involved to secure funding from some sources, especially government.

> *When it comes to community-based solutions that might benefit GBMSM who use substances, it's very complicated for community members to apply for funding. Funding applications are prohibitively complex, difficult to navigate and too tied to research. It would be great to see funding set aside, including by PHAC [Public Health Agency of Canada] and other government funders, that is dedicated to community organizations doing local, smaller-scale projects that does not require a post-doc to apply for.*
>
> — Key informant

Gaps in what services are funded are also sometimes the downstream effect of gaps in the research, which then perpetuates the problem because there isn't as clear "evidence of need," even if community-level experience is that harms are occurring.

> *When chemsex became a phenomenon that gained more public attention, what became immediately apparent to me is that much of the funding for programming addressing our communities' needs was created by and for the GBMSM community. While there is a very real need for harm reduction support that is targeted to this community, we have also seen that this need extends to the 2SLGBTQ+ community as a whole. The problem seems to be that there is a significant lack of research — which ultimately translates to funding — extended to the rest of the queer communities' unique needs.*
>
> — Jess Murray, Queer and Trans Health Collective (Edmonton)

Legal and policy changes

In light of the harm caused by drug prohibition, including and especially to the health of people who use drugs, calls for *decriminalization* of simple possession are growing, including being recommended unanimously by all UN agencies.[346] British Columbia currently has in place a three-year exemption (until early 2026) from federal law criminalizing simple possession, albeit with unnecessary and unhelpful restrictions.[347] A request from the City of Toronto for a municipal exemption is still under consideration by Health Canada. In line with this, key informants were unanimous in their strong view that legal and policy changes are needed as part of responding effectively to problematic substance use, including among GBT2Q people, including decriminalizing possession. It was also noted that the protection against possible criminal charges for possession afforded by the *Good Samaritan Drug Overdose Act* needs to be expanded. Related to this, aside from what the law may say on paper, as a matter of practice, having police attend respond to a call for emergency services from the scene of an overdose is unhelpful and a barrier to care.[348]

The two biggest barriers are criminalization and stigma. Criminalization impacts all communities — it is THE most pressing barrier to attend to. Criminalization feeds into stigma, and stigma is one of the biggest barriers for GBMSM who use drugs to accessing healthcare and other supports. Stigma and moralizing narratives about drugs make it impossible to have rational, honest, and public conversations about our own substance use and creates the silence that keeps us in the closet about substance use.

— Jordan Bond-Gorr, Gay Men's Sexual Health Alliance (Toronto)

In addition, several key informants called for scaling up access to "safe supply," including through legalizing and regulating the supply of substances to better protect the health of consumers.

We need decriminalization of drugs, perhaps legalization. This would lead to fewer people being punished and imprisoned for using substances, which makes no sense — why are we making these people's lives harder by giving them a criminal record? It would lead to less violence and crime. It would mean less stigma and a less toxic supply of drugs. It would allow people to speak more openly about substance use and allow for earlier interventions and better access to supports.

— Andrew Thomas, AIDS Coalition of Nova Scotia (Halifax)

We need legal regulation, in addition to decriminalization — and we need to think about the models for that, including going beyond a medical model. Probably going the buyers' compassion clubs is the way to go, and being more critical of alcohol and tobacco models, with such blatant commercialization of those drugs. If we're talking about harm to gay men from substance use, when are we going to talk about alcohol?

— Nick Boyce, Canadian Drug Policy Coalition (Ottawa)

One example of a need for an improved approach to legal regulation is the case of poppers, commonly used by GBMSM in conjunction with sex. In Canada, it is not illegal to possess poppers for personal use. However, in 2013, Health Canada began a crackdown on the sale of poppers, taking the (disputed) position that they are "drugs" under the *Food and Drugs Act* and therefore selling them without authorization (of the kind required for

pharmaceutical products) is an offence punishable with fines and/or imprisonment. Despite this, use of poppers among GBMSM remains high, with multiple studies showing recent use by nearly one-third of GBMSM (and by half of those living with HIV).[349] The harms of Canada's prohibition on poppers have recently been analyzed elsewhere, with advocates calling for an end to the ban as unwarranted and as doing more harm than good, particularly to GBMSM.[350]

Some key informants also called for efforts to undo the harm of being saddled with a criminal record for drug charges.

> *I know enough gay guys who've got criminal charges related to drug use, so expungement of records would be an important area for advocacy.*
> — Nick Boyce, Canadian Drug Policy Coalition (Ottawa)

As detailed above, the stigmatization and criminalization of sex work harms the mental and physical health of GBT2Q sex workers, including by increasing exposure to violence and impeding their access to harm reduction services,[351] and sex workers across Canada have called for law reform to better protect health and human rights, with decriminalization of sex work as a priority.[352] Some key informants also noted how the continued criminalization and stigmatization of sex work further burdens some GBT2Q people who use drugs and mentioned the need for law reform on this front.

> *In 2018, we conducted a survey on sexualized substance use, and we've just finished redoing it to look at the needs of the whole 2SLGBTQ+ community in Alberta. Through that survey, we learned some valuable lessons. We discovered that the needs of the GBMSM community differ from other parts of the queer community. One example being trans sex workers: while some trans sex workers engage in sexualized substance use without issue, others struggle with it. Some of us use substances as a coping mechanism or because we feel isolated from our community. This isolation can lead to problematic substance use, much like it can among GBMSM.*
> — Jess Murray, Queer and Trans Health Collective (Edmonton)

Aside from specific legal changes, key informants also agreed that governments need to incorporate 2SLGBTQ+ people and their specific needs into relevant strategies and policy initiatives, not just those in relation to drugs specifically but other related determinants of health and health outcomes (e.g. housing, poverty reduction, sexual health).

SCAN OF RESOURCES, SERVICES, AND FEDERAL STRATEGIES AND FUNDING

Over the past decade, there has been a welcome increase in resources aimed at supporting GBT2Q who use drugs to protect and promote their health, reflecting the growing evidence base and attention to the issue, but overall, they remain insufficient in number and insufficiently resourced.

Educational resources

Several (mostly online) information resources exist to provide harm reduction information to GBT2Q people who use drugs. The most recent of these include GMSH's **"Party and Play" website** and **Your Party and Play Field Guide**, a harm reduction handbook with practical tips produced in collaboration with CATIE. In addition to these useful static information resources, **MonBuzz/MyBuzz** (**www.monbuzz.ca / www.MyBuzz.ca**) is a bilingual online tool, developed by RÉZO and l'Université de Sherbrooke, to help GBMSM assess their drug and alcohol use and consider the effects these may be having on their sex life and sexual health. It is available as an interactive website and occasionally promoted via at least some mobile social networking apps (e.g. Grindr, Scruff). At certain times, the online assessment is backed by access to online chat with a counsellor.[353]

Services

CBRC maintains a periodically updated **national map of services related to PnP**. Several organizations addressing the health of GBT2Q people have integrated harm reduction and other services for people who use drugs into their programming, and some also have specific services for particular communities among GBT2Q people, such as those who do sex work. A few other organizations focusing on HIV among particular communities — such as specific ethno-racial communities or people currently or formerly in prison — have included programs for GBT2Q people and/or people who use drugs in their services. Among the services being provided to varying degrees are the following:

- **harm reduction education,** including through workshops and presentations, which sometimes include training on use of naloxone for reversing opioid overdose;
- **drop-in supports**, sometimes oriented to specific communities, with some taking place in-person, others online as virtual drop-ins (and some in a hybrid format);
- **counselling and other psychosocial support services**, including both individual and group counselling (also sometimes available through health centres specializing in queer and trans health);
- **distribution of harm reduction (and safer sex) supplies** in various ways, including: onsite at their premises; through street outreach programs and other mobile outreach (e.g. van/bus); in some cases, distribution of at least harm reduction *information* (but not supplies) in spaces such as bars and sex-on-premises venues (e.g. bathhouses) and at GBT2Q-specific specific events; delivery by mail; and direct, in-person delivery of harm reduction (and safer sex) supplies to a private residence or other location; and
- **drug checking services** (e.g. FTIR spectrometers in some cases, but at least fentanyl test strips, which many also offer for take-home use; some organizations also provide benzodiazepine test strips).

Training of service providers

Some organizations offer training specifically for providers of health and other social services, with a view to assisting them in becoming more culturally competent to meet the needs of 2SLGBTQ+ people, including in relation to sexualized substance use. Examples include: the Intersexion community of practice and virtual training platform for service providers regarding sexualized drug use, hosted by the Association des intervenants en dépendance du Québec (AIDQ); the multi-part video series of e-learning modules produced by St. Stephen's Community House in Toronto; GMSH's www.PartyandPlay.info website, which hosts a secondary site specifically for service providers, and its interactive training sessions providing an "Introduction to Chemsex/PnP" for front-line sexual health and harm reduction staff, physicians, and other clinical care providers; and a module on "Substance Use Care for 2SLGBTQ+ People" in the Addiction Care and Treatment Online Course (ACTOC) for healthcare practitioners by the University of British Columbia. Both the GMSH and UBC training sessions are certified for continuing professional development credits.

Federal strategies and funding

There are important examples of *some provincial and municipal governments* funding initiatives to address problematic substance use among GBT2Q+ people, including harm reduction services, but it was beyond the scope of this project to do a comprehensive scan of these. A snapshot of recent/current funding at the *federal level*, in relation to (i) health, (ii) drugs, and (iii) 2SLGBTQ+ communities, suggests that some important initiatives have been supported, but funding is short-term, *ad hoc*, and far from adequate. There is an opportunity and a need to strengthen attention to the health of GBT2Q people who use drugs in all of these.

STBBIs and/or sexual health

In Canada, the burden of HIV falls most heavily on GBMSM and significantly on people who inject drugs, and the specific population of GBMSM who inject drugs is considered epidemiologically significant enough to warrant its own specific category in PHAC's HIV surveillance data.[354] Yet neither the *pan-Canadian framework* for action on STBBIs, nor the *federal government's action plan* to address STBBIs (as a component of that national framework), make any mention of problematic substance use among GBT2Q people or the need for harm reduction efforts specifically engaging this population.[355]

As for funding, the Public Health Agency of Canada administers both the ***HIV and Hepatitis C Community Action Fund*** (CAF), to support efforts at HIV prevention, testing, linking people to care, and reducing stigma, and the ***Harm Reduction Fund***, to support front-line interventions to reduce HIV and HCV among people who use drugs. The CAF currently supports one "community alliance" project focused, in part, on addressing substance use among GBT2Q men, through interventions by GBT2Q community organizations. Under its previous three-year funding cycle (ended March 2022), the HRF supported projects by three community organizations. In the current

funding cycle (2022-2025), the HRF is again supporting service delivery by three community organizations, as well as the small project by the HIV Legal Network that includes production of this report and related resources on strengthening harm reduction among GBT2Q men and gender-diverse people. Finally, in its 2021 budget, the federal government committed $45 million over three years to support work on advancing ***sexual and reproductive health***, including via supporting the Sexual and Reproductive Health Unit of Health Canada and providing funding for community organizations (to be managed and disbursed by that Unit). That funding is supporting important initiatives, including in relation to the sexual health of 2SLGBTQ+ people. Based on the information publicly available online and informal inquiries, it does not appear that any projects have been funded from this source that address sexualized drug use among GBT2Q people as part of protecting and promoting sexual heath.

Drugs and substances

The federal government launched a retooled *Canadian Drugs and Substances Strategy* in December 2016, restoring harm reduction as a pillar of such a strategy.[356] As part of this strategy, Health Canada administers the ***Substance Use and Addictions Program*** (SUAP), which funds "a wide range of evidence-informed and innovative problematic substance use prevention, harm reduction and treatment initiatives across Canada at the community, regional and national levels."[357] In 2022, SUAP provided one year of funding to CBRC for a national PnP project that allowed for the expansion of the "Peer N Peer" program, a peer-led queer substance use and sexual health program started by QTHC in Edmonton and MAX Ottawa, to two new partner organizations, SERC in Winnipeg and the AIDS Coalition of Nova Scotia in Halifax, but funding ended after just one year. In addition, in the current funding cycle, SUAP has supported seven projects of varying size and duration (some ended as of March 2023, others continuing until early 2024) that explicitly include GBT2Q people who use drugs (although not necessarily exclusively or primarily).

2SLGBTQ+ communities

In late 2022, the federal government commendably launched the *Federal 2SLGBTQI+ Action Plan: An Ongoing Commitment to Action*, accompanied by a commitment in Budget 2022 of CAD $100 million over five years to develop and implement initiatives that advance the objectives of the Action Plan. The Action Plan identifies six priority areas and related objectives, including the following: sustaining 2SLGBTQI+ community organizations in advocating for and serving their communities; supporting the resilience and resurgence of Indigenous 2SLGBTQI+ communities; improving data collection, analysis, research, and knowledge on 2SLGBTQI+ communities in Canada; and strengthening mechanisms to advance 2SLGBTQI+ issues and ensure coordinated Government of Canada responses to community priorities.[358] Addressing the needs of 2SLBTQI+ people who use drugs is a necessary part of each of these areas. Yet neither the Action Plan nor any of the funding calls to date — which also explicitly state that they will "prioritize funding for 2SLGBTQI+ communities experiencing additional marginalization" — make mention of 2SLGBTQ+ people who use drugs or of the need for research, services, and policies to address this aspect of queer communities' health.

CONCLUSION

Problematic substance use, including sexualized use, is a significant health concern among GBT2Q people, including in relation to HIV and other STBBIs, but also beyond. Reducing the harms associated with problematic drug use, and with problematic drug policy, warrants greater sustained attention, from governments, service providers, and advocates, including harm reduction and drug policy advocates and advocates for the rights of 2SLGBTQ+ people.

GBT2Q people have particular relationships to substances that, for a range of reasons and in a variety of ways, are informed by sexual or gender minority identities. In addition, specific populations of GBT2Q people may face additional forms of stigma or have additional needs that must be considered in responding effectively to reduce harms and promote health. So, too, must interventions be designed in a fashion that recognizes and values the benefits, including pleasure and connection, that GBT2Q people derive from their use, in addition to communicating information to help people reduce risks when using. Service providers and policymakers must avoid the non-evidence-based, stigmatizing, and ultimately harmful rush to deem all substance use harmful or problematic, and to further pathologize sexual and gender minorities who use drugs.

Layered on top of insufficient and inaccessible services, criminalization and stigma create additional, significant barriers to needed interventions to protect the health of GBT2Q people who use drugs. That stigma unfortunately also exists within the GTB2Q community despite the higher prevalence of substance use, including sexualized use, among GBT2Q people. Often “mainstream” services, whether for treatment or harm reduction, are not well equipped to address the needs of GBT2Q people, and even more so for those who engage in chemsex/PnP. Proactive measures, including policy steps, can and should be taken to improve their cultural competence, as a matter of good practice and equity. But there is also a need to expand access to services by and for GBT2Q people. Such services should incorporate peers with their own experience of substance use, not only as a recipients and participants of services, but also as employed service providers.

GBT2Q people need access to a broader range of interventions, both pharmacological and psychological, for treating or reducing the harm of problematic drug use among GBT2Q people. Meanwhile, interventions to reduce harms among those who use drugs should be made friendlier and more accessible to GBT2Q people, including through their delivery in GBT2Q community spaces, both physical and virtual. In addition, services for treating problematic substance use and reducing harms of substance use need to be integrated, where appropriate, with other related services such as those for mental health and sexual health. Attending effectively to problematic substance use among GBT2Q people also often requires addressing the broader range of social determinants of health for GBT2Q people, from homophobia and other forms of stigma, discrimination, and violence to basic needs such as income security and housing. Easier access to more sustained, reliable funding for research and for interventions, including those delivered by frontline, community-based organizations, is essential. In addition, all orders of government should incorporate attention to problematic substance use among GBT2Q people in relevant strategies and initiatives and should repeal harmful drug laws and policies; this includes decriminalizing simple possession of currently criminalized substances.

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[230] Watson RJ et al. Associations Between Community-Level LGBTQ-Supportive Factors and Substance Use Among Sexual Minority Adolescents. *LGBT Health* 2020; 7(2): 1-8.

[231] Goodyear T et al, supra.

[232] Belak B et al. Position Paper: Sex Work Law Reform: Implications for Male Sex Workers in Vancouver and Beyond. Vancouver: Health Initiative for Men, 2013, https://checkhimout.ca/wp-content/uploads/2013/07/HIM-Position-Paper-Sex-Work-Law-Reform-2.pdf.

[233] Matthen P et al. "I walked into the industry for survival and came out of a closet:" How gender and sexual identities shape sex work experiences among men, two-spirit and trans people in Vancouver. Men and Masculinities 2018; 21(4): 479-500. They also note that, for some, sex work has been a means of expressing and exploring stigmatized aspects of their identities, contrary to the assumption, embedded in current Canadian law, that sex work is inherently oppressive and exploitative.

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[240] E.g. see the perspectives of sex workers reflected in the community-based research report *Challenges: Ottawa area sex workers speak out*, *supra* and Gerrard-Martinez, *supra*; Jiao Z, Bungay V. Intersections of stigma, mental health and sex work: How Canadian men engaged in sex work navigate and resist stigma to protect their mental health. *Journal of Sex Research* 2019; 56(4-5), 641-649; Siegel K et al. Perceived Stigma and Stigma Management Strategies Among Online Male Sex Workers. *Arch Sex Behav* 2022; 51(5): 2711-2730.

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[242] Goldenberg S et al. Police-related barriers to harm reduction linked to non-fatal overdose amongst sex workers who use drugs: Results of a community-based cohort in Metro Vancouver, Canada. Int J Drug Policy 2020; 76: 102618,

[243] Armstrong et al, supra.

[244] See companion document for more detailed review of the evidence regarding socio-economic status and sexual orientation, and the relationships between income, homelessness, and substance use among GBT2Q people.

[245] Anderson-Carpenter et al, supra.

[246] Li MJ et al. Intersecting burdens: Homophobic victimization, unstable housing, and methamphetamine use in a cohort of men of color who have sex with men. Drug Alcohol Depend 2018; 192: 179-185.

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[252] Ecker J et al. A Review of the Literature on LGBTQ Adults Who Experience Homelessness. *Journal of Homosexuality* 2017; 66(3): 297.

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[255] Fraser B et al. LGBTIQ+ Homelessness: A Review of the Literature. *Int J Env Res Pub Health* 2019; 16: 2677. See also: McCarthy L & Parr S. Is LGBT homelessness different? Reviewing the relationship between LGBT identity and homelessness. *Housing Studies* 2022 (online 10 Aug).

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[259] Public Safety Canada. *2021 Corrections and Conditional Release Statistical Overview*. Ottawa, 2023. See also the first Canadian study presenting detailed incarceration rates by race, reporting substantial over-representation of Black men in provincial correctional facilities in Ontario, and that a large proportion of Black men experience incarceration: Owusu-Bempa A et al. Race and Incarceration: The Representation and Characteristics of Black People in Provincial Correctional Facilities in Ontario, Canada. *Race and Justice* 2021: 21533687211006461.

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[261] Jacobsen K et al. Prevalence and Correlates of Incarceration Among Trans Men, Nonbinary People, and Two-Spirit People in Canada. *Journal of Correctional Health Care* 2023; 29(1): 47-59.

[262] Scheim A et al. Joint Effort: Prison Experiences of Trans PULSE Participants and Recommendations for Change. *Trans PULSE E-Bulletin* 2013 (April 22); 3(3).

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[269] E.g. Canadian Medical Association, Resolution 26 of 17 August 2005; Canadian Public Health Association. Intervener Factum in Simons et al v. Minister of Public Safety et al, 2020 ONSC 1431 (CanLII); United Nations Office on Drugs and Crime. A Handbook for Starting and Managing Needle and Syringe Programmes in Prisons and Other Closed Settings. Vienna: UNODC, 2014; UNAIDS. Fact Sheet: HIV and People in Prisons and Other Closed Settings. Geneva: UNAIDS, 2021; Office of the Correctional Investigator. Office of the Correctional Investigator Annual Report 2021-2022. Ottawa: OCI, 2022.

[270] Kidd JD et al. A scoping review of alcohol, tobacco, and other drug use treatment interventions for sexual and gender minority populations. *J Subst Abuse Treat* 2022; 133: 108539.

[271] Centre for Addiction and Mental Health. *Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder.* Toronto: CAMH, May 2021.

[272] E.g. Girouard MP et al. Understanding and treating opioid use disorders in lesbian gay, bisexual, transgender, and queer populations. *Subst Abuse* 2019; 40(3): 335-9.

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[274] *Ibid*; Karamouzian M. "What works for methamphetamine use disorder? A systematic review of reviews," in: *Methamphetamine and Related Psychostimulant Use: End-of-Grant Workshop – What We Heard Report.* Canadian Institutes for Health Research, 15 February 2022; Li M, Shoptaw S. Clinical management of psychostimulant withdrawal: review of the evidence. *Addiction* 2023; 118(4): 750-762.

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