Drug use in LGBT+ communities and chemsex: call for evidence

Section 2: Community context and observation

Q2a) From your experience, what substances are most commonly used recreationally (including where possible detail regarding routes of administration) in different LGBT+ sub-groups, including in chemsex contexts?

Among gay, bisexual and other men who have sex with men (GBMSM), chemsex is most commonly associated with the use of GHB/GBL (typically taken orally), crystal methamphetamine (smoked or injected, including "slamming"), mephedrone (injected or snorted), and cocaine (usually snorted). Substance use in these contexts is often linked to prolonged sessions, group sex, and app-facilitated sexual encounters, which can increase both health risks and patterns of intensive use.

For trans and gender-diverse people, some services report higher levels of co-occurring use of alcohol, benzodiazepines, and opioids, frequently alongside experiences of poor mental health. In addition, some trans people report using recreational substances as a way to alleviate gender dysphoria, or as a coping strategy where access to timely, appropriate gender-affirming healthcare is limited or unavailable.

Among lesbian, bisexual and queer women, substance use is more commonly reported to involve alcohol, cocaine, MDMA, and ketamine, with routes of administration typically non-injecting. Use is less often associated with chemsex contexts and more commonly occurs in social or recreational settings.

Younger LGBT+ people are more likely to report the use of cannabis, MDMA, ketamine, and recreational stimulants, generally outside of chemsex contexts. This use often reflects broader youth drug trends, shaped by social environments, nightlife, and peer networks, rather than sexualised drug use.

Q2b) Are there particular demographic trends that stand out in your observations? Relevant demographics include age, ethnicity, gender identity, sexual orientation, disability, neurodivergence, socioeconomic status and migration status, among others.

Chemsex is most commonly observed among men aged approximately 25–50, with White British men often over-represented in specialist chemsex services. This likely reflects a combination of service access, referral pathways, and reporting patterns, rather than an absence of need among other ethnic groups.

Chemsex use is observed across the socioeconomic groups. It occurs among individuals who are economically secure, including those in stable employment and housing, as well as among people experiencing housing insecurity, unstable employment, or wider social disadvantage. This breadth highlights that chemsex-related harms are not confined to a single socioeconomic group, although the nature and severity of associated risks may differ depending on an individual's circumstances and access to support.

Q2c) Have you noticed any regional differences in the prevalence or nature of recreational drug use in LGBT+ communities, including chemsex?

Chemsex is more visible and more frequently identified in large urban areas, where there are stronger links between sexual health services, drug and alcohol provision, and established LGBT+ community infrastructure. These connections increase opportunities for identification, referral, and support..

However, chemsex is also present in smaller cities and rural areas, where it is often more hidden. In these areas, fewer specialist services and weaker referral pathways mean that engagement is more limited and harms may go unidentified for longer.

In addition, people living in rural or semi-rural areas often travel to larger cities to participate in chemsex-related parties, meaning there may be no distinct local chemsex scene. This can increase barriers to ongoing engagement, continuity of care, and access to peer support networks. As a result, regional variation in reported prevalence frequently reflects service availability and community infrastructure, rather than differences in underlying need.

Q2d) Are there any demographic trends (e.g., age, ethnicity, gender identity) that stand out in your observations?

Across services, gay, bisexual and other men who have sex with men are disproportionately represented among those experiencing chemsex-related harms. This reflects both higher prevalence within this group and greater visibility through sexual health and specialist services.

Trans people often report additional barriers when seeking support, with drug and alcohol use frequently intersecting with experiences of poor mental health, trauma, discrimination, and unmet healthcare needs. These intersecting factors can increase both vulnerability to harm and complexity of presentation.

Q2e) Have you observed any changes over time in the prevalence or nature of recreational drug use in LGBT+ communities, including chemsex?

There appears to be an increased normalisation of chemsex, including greater

familiarity with chemsex-related language, practices, and social norms within some LGBT+ networks.

Services are also observing greater polysubstance use, particularly the combination of GHB/GBL with stimulants such as crystal methamphetamine and mephedrone, alongside increased use of substances such as 2CB and other psychedelics in sexualised contexts.

While awareness of harm reduction has improved, people often present late to services, frequently when harms have escalated or become acute, limiting opportunities for early intervention.

Section 3: Perceived harms and health impacts

Q3a) What types of harms have you observed in relation to recreational drug use, including chemsex, in LGBT+ communities (e.g., physical, mental, social), and what has been the impact? Where relevant, please include detail regarding routes of administration (e.g. injecting).

Services observe a range of physical, mental, and social harms associated with recreational drug use and chemsex. Physical harms include overdose, particularly involving GHB/GBL, as well as increased overdose risk associated with polydrug use. Injecting-related harms include vein damage, abscesses, blood-borne virus risk, and sexual health harms.

Mental health impacts commonly include anxiety, depression, paranoia, psychosis, and suicidality, particularly following prolonged or repeated chemsex sessions.

Social harms include relationship breakdown, loss of employment, housing instability, and involvement with the criminal justice system. Injecting or “slamming” is associated with higher dependency risk, more rapid escalation of use, and sexual dysfunction.

Q3b) Are there any specific concerns around consent, safety, or trauma in these contexts?

Chemsex contexts can involve blurred or absent consent, particularly where individuals are heavily intoxicated or unconscious. Services report increased disclosures of sexual assault, coercion, and exploitation in these settings.

For some individuals, chemsex can also re-trigger past trauma, particularly among those with histories of abuse, discrimination, or marginalisation.

Q3c) Have you observed any patterns in how these harms manifest (e.g., frequency, severity, co-occurring harms and health impacts)?

Harms rarely occur in isolation and often compound over time, with mental health difficulties, sexual health harms, and dependency reinforcing one another. Many people experience escalation from episodic or recreational use to more frequent, chaotic, or dependent patterns.

Help-seeking is often delayed until crisis point, such as overdose, acute mental health deterioration, or relationship or housing breakdown.

Section 4: Access to services and support

Q4a) What types of services or support are available specifically for LGBT+ people experiencing harms related to drug use, including chemsex?

Many services now offer LGBT+-inclusive drug and alcohol services, such as groups within mainstream services. More sexual health clinics are now offering chemsex-related support, and links to peer-led community and online support groups. However, specialist chemsex programmes remain limited and unevenly distributed, resulting in variable access depending on geography.

Q4b) From your observation, where do people experiencing harm typically seek help (e.g., sexual health clinics, community organisations, online)?

Sexual health clinics are often the first point of contact, particularly where harms are identified through STI testing or HIV care. People may also initially seek support through informal peer networks or online forums and apps. Engagement with structured drug and alcohol treatment often occurs later, when needs have become more complex or severe.

Q4c) What barriers have you observed that prevent LGBT+ individuals from accessing support or treatment? Are there any concerns of stigma, discrimination, or lack of understanding from general population services (e.g., mental health services, addiction services, sexual health services etc.)?

A key barrier is the lack of specialist services. Where specialist provision does exist, it is often primarily focused on chemsex and on gay, bisexual and other men who have sex with men. This can unintentionally exclude or deter LGBTQ+ women, whose needs may not be reflected in service design or delivery. The gendered nature of many treatment settings, which are frequently male-dominated, can further compound this barrier and reduce feelings of safety or relevance for LGBTQ+ women.

Many individuals also report a fear of stigma and discrimination, alongside a lack of cultural competence within some general population services. Concerns about being misunderstood, judged, or having to repeatedly explain one's identity can discourage

engagement or lead to early disengagement.

Fragmented pathways between sexual health, mental health, and substance use treatment services present additional barriers, particularly for people with multiple or intersecting needs. Poor coordination can result in repeated assessments, inconsistent messaging, and gaps in care.

Concerns about confidentiality are also common, particularly in smaller communities or where services are closely linked to other health or social care provision.

For trans people, limited availability of trans-inclusive services presents a significant barrier. There is also widespread fear that accessing mental health services or substance use treatment may negatively affect access to transition-related healthcare, which can lead to avoidance of support or delayed help-seeking.

Section 5: Interventions and harm reduction

Q5a) Are you aware of any effective interventions or harm reduction strategies specifically tailored to LGBT+ communities or in chemsex contexts?

Effective interventions and harm reduction strategies for LGBT+ communities, including in chemsex contexts, include non-judgemental, inclusive approaches that prioritise safety and respect for lived experience. Peer-led chemsex groups and dedicated LGBTQ+ peer support networks have proven valuable in providing culturally competent advice, guidance, and emotional support.

Integrated services that combine drug and sexual health support, and that link with victim and survivor services, help address the complex and intersecting needs of individuals engaging in chemsex. Targeted outreach, delivered through dating apps and community spaces, increases awareness of harm reduction strategies and facilitates earlier engagement with services.

Partnerships between mainstream drug and alcohol providers and LGBTQ+ community-led support organisations help ensure that interventions are both accessible and tailored to the specific needs of diverse LGBTQ+ populations.

Q5b) What approaches or interventions do you think are most helpful in reducing the harms associated with chemsex?

Early intervention, before dependency develops, is critical. Clear, accessible guidance on GHB/GBL dosing, injecting safety, and overdose response is particularly important. Trauma-informed services and strong referral pathways between sexual health, mental health, and substance use services are also key.

Q5c) Do you feel that individuals engaging in chemsex are adequately informed

about the risks of chemsex and harm reduction strategies? What educational resources or campaigns do you think would be beneficial?

While awareness of risks and harm reduction strategies exists, it is uneven and often informal. Awareness also often lacks nuance of different forms chemsex can be, e.g. many people see it as only large group parties rather than also any context in which substances are used to enhance sexual experiences (e.g. only with one partner)There is a need for clearer, consistent, and nationally endorsed resources. Digitally delivered, peer-co-produced education and campaigns are likely to be most effective.

Section 6: Recommendations

Q6a) What changes would you recommend to improve support, reduce harm, and better inform LGBT+ individuals experiencing drug-related harms?

A key barrier to understanding the needs of LGBTQ+ communities is the lack of consistent data, as sexual orientation and gender identity are not currently mandatory fields within the National Drug Treatment Monitoring System (NDTMS). This limits the ability to accurately monitor trends, assess need, and design targeted interventions.

There is a clear need to strengthen integration and referral pathways between sexual health, mental health, and substance use services, to ensure that people with intersecting needs can access timely and coordinated support.

Services should also increase focus on the diverse needs within LGBTQ+ communities. Specialist services are often heavily focused on chemsex and gay, bisexual, and other men who have sex with men, which can leave LGBTQ+ women, trans, and non-binary people underserved. For example, attention should be given to the links between experiences of conversion therapy or other forms of identity-based trauma and increased substance use.

Additionally, drug and alcohol providers have a role in reducing harms associated with the use of illicit or DIY hormone therapy (HRT) among trans and non-binary communities. Currently, harm reduction guidance for DIY HRT is limited, and clearer, evidence-informed support is needed to reduce risks.

Q6b) Are there any policies, guidelines, or service models you believe should be adopted or expanded?

Commissioning models should support integrated and specialist provision, including sustainable funding for partnerships between mainstream services and LGBTQ+ community-led organisations.

Q6c) What would make general population services (e.g., mental health services,

addiction services, sexual health services etc.) more accessible, welcoming or safe to LGBT+ individuals?

General population services would be more accessible through mandatory LGBT+ cultural competence training, inclusive language and monitoring, visible signals of safety, and meaningful co-production with LGBTQ+ communities. Flexible, non-abstinence-based pathways and dedicated LGBTQ+ spaces within services would further improve engagement.