ACMD

Advisory Council on the Misuse of Drugs

Drug use and chemsex in the LGBT+ community

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1. Report terminology

A number of different terms are used generally and throughout the report to refer to specified populations within the wider LGBT+ communities. These include:

- **Cisgender:** A term used to refer to any individual whose gender identity or expression aligns with the sex they were assigned at birth.
- **Gay, Bisexual, and other Men who have Sex with Men (GBMSM):** This refers to any men who engage in sexual activity with other men.
- **Lesbian, Gay, Bisexual (LGB)**: This term is used when data collected includes sexual orientation *but not* gender identity.
- **Lesbian, Gay, Bisexual, Transgender (LGBT)**: This term is used when data collected includes both sexual orientation *and* gender identity.
- **Lesbian, Gay, Bisexual, Transgender plus (LGBT+)**: This term is used when data collected includes both sexual orientation and *all* gender identities. This term is also used as an umbrella term to refer to the wider LGBT+ community.
- **Transgender and Non-binary (TGNB):** An umbrella term used to refer to any individual whose gender identity or expression differs from the sex they were assigned at birth. It includes transgender men, transgender women, and non-binary people.
- **Women who have Sex with Women (WSW):** This refers to any women who engage in sexual activity with other women.

2. Introduction

2.1. The Advisory Council on the Misuse of Drugs (ACMD) has previously investigated vulnerability to and risk factors for substance use [ACMD, 2018] and use in specific vulnerable groups including those who are homeless [ACMD, 2019], young people [ACMD, 2022] and ethnic minority groups [ACMD, 2026a] to make suitable recommendations. This report focuses on drug use in lesbian, gay, bisexual, transgender plus (LGBT+) communities.

2.2. In 2024, an estimated 2.1% (1.2 million) of the UK adult population identified as gay or lesbian, and 1.6% (855,000) identified as bisexual, an increase from 2019 of 1.6% and 1.1% respectively. In 2024, men were more likely to identify as gay (2.9%) than bisexual (1.1%), while women were more likely to identify as bisexual (2.0%) than gay or lesbian (1.4%) [ONS, 2025a].

2.3. Younger people (16–24 years) were more likely to identify as lesbian, gay or bisexual (LGB) than older people (65+ years); 8.0% of people aged 16–24 years identified as LGB, compared with 1.2% of people over 65 years old. In 2024, a higher proportion of people aged 16–24 identified as bisexual (5.1%) than gay or lesbian (2.9%) [ONS, 2025a].

2.4. The 2021 England and Wales Census included a question on gender identity for the first time. Across England and Wales, 94.0% (45.7 million) of people aged 16 years and over responded to this question with 0.5% (262,000) reporting having a gender identity different from their sex registered at birth. Within this group, 0.1% (48,000) identified as a trans man, 0.1% (48,000) identified as a trans woman and 0.06% (30,000) as non-binary [ONS, 2023a]. However, analysis by the Office for National Statistics (ONS) suggests that language barriers (proficiency in English) may have led some respondents to misinterpret this question, introducing uncertainty into the estimates [ONS, 2023b].

2.5. Substance use among LGBT+ individuals in the UK remains an important public health issue, shaped by a mix of social, structural, and cultural factors. Research consistently shows that substance use among LGBT+ people is high, with these communities more likely to report using alcohol, tobacco and a range of illicit or recreational drugs than their heterosexual and cisgender peers.

2.6. These disparities in substance use among sexual minorities are not specific to the UK and have been documented in other countries, including Australia [AIHW, 2026], Brazil [Gomes and Lopes, 2023] and the USA [Mestre et al., 2024; SAMHSA, 2016, 2023; Schuler et al., 2020; Paschen-Wolff et al., 2024].

2.7. This report examines substance use among LGBT+ communities across the UK, with a specific focus on sexualised drug use, chemsex (section 6), and the substances used in these settings.

2.8. Several previous ACMD reports have addressed the harms of substances contained within this report, including cocaine, gamma hydroxybutyric acid (GHB), gamma-butyrolactone (GBL), ketamine, 3,4-methylenedioxymethamphetamine (MDMA), mephedrone, methamphetamine and nitrites (Table 1), and can be accessed by those requiring more drug specific information.

Table 1: *Published reports on the patterns of use and harms of substances contained within this report.*

Cocaine	Cocaine powder: review of its prevalence, patterns of use and harm [ACMD, 2015]
GHB/GBL	Assessment of the harms of gamma-hydroxybutyric acid, gamma-butyrolactone, and closely related compounds [ACMD, 2020]
Ketamine	Ketamine: an updated review of use and harms [ACMD, 2026b]
MDMA	MDMA (‘ecstasy’) review [ACMD, 2009]
Mephedrone	Synthetic cathinones: an updated harms assessment [ACMD, 2025a]
Methylamphetamine	Methylamphetamine review [ACMD, 2005]

Nitrites	Alkyl nitrites ('poppers'): updated harms assessment and consideration of exemption from the Psychoactive Substances Act (2016) [ACMD, 2024]
Multiple	Club drug use among Lesbian, Gay, Bisexual and Transgender (LGBT) people [NEPTUNE, 2016]

3. Prevalence of substance use among LGBT+ communities in the UK

Summary

- Evidence consistently shows that LGBT+ populations experience higher rates of substance use and hazardous consumption than cisgender heterosexual populations.
- However, the evidence is largely focused on cisgender gay, bisexual, and men who have sex with men (GBMSM) populations in the context of sexualised drug use and chemsex. Research on substance use among cisgender women who have sex with women (WSW) and transgender and non-binary (TGNB) people remain scarce.

3.1. Evidence consistently shows that LGBT+ populations experience higher levels of substance use and hazardous consumption compared with cisgender heterosexual populations [NEPTUNE, 2016; IAS, 2021; UKDPC, 2010; Marshal et al., 2008].

3.2. Analysis of the combined 2007 and 2014 Adult Psychiatric Morbidity Survey (APMS) (*n* =10,443) found higher rates of past-year illicit-drug use among 16– to 64- year-olds identifying as bisexual (37.0%) and lesbian or gay (25.3%) compared with those identifying as heterosexual (10.5%) or 'other' (8.5%) [Pitman et al., 2022]. APMS data gathered in 2023/2024 found 23.9% (66/278) of adults identifying with a sexual minority status reported drug use in the past year, compared to 9.1% of (511/5,611) adults identifying as heterosexual [Communication and data sharing from APMS study team, July 2026].

3.3. The Crime Survey for England and Wales (CSEW) for March 2024–March 2025 found past-year drug use to be 18.0% (64/352) among gay/lesbian adults, 27.5% (149/541) among bisexual adults and 17.6% (22/125) among 'other' adults compared with 7.8% (1,152/14,774) among heterosexual adults [ONS, 2025b].

3.4. A report by the UK Drug Policy Commission (UKDPC) noted use of cannabis, amyl nitrite ('poppers'), cocaine, and ecstasy was higher among LGB communities compared to heterosexual communities, with gay men reporting higher overall use of drugs in the past year compared to other LGBT groups [UKDPC, 2010]. LGBT+ people have also been 'early adopters' of some new drug trends, such as club drugs and novel psychoactive substances (NPS) [NEPTUNE, 2016].

3.5. In November 2025, Antidote, a UK-based LGBT+ drugs and alcohol support service, ran a survey in partnership with the charity LGBT HERO seeking the views of LGBT+ people who had a support need around their drug and alcohol use. Of the 334 respondents, 79% reported having used drugs in the previous year, and 69% specifically for chemsex. Antidote services saw an 18% increase in clients compared to the previous year (374 in 2023/2024 to 441 in 2024/2025) indicating an increase in demand for services and support [London Friend, 2026].

3.6. LGBT+ communities are diverse, and substance use trends vary across demographic characteristics, including sexual orientation and gender, as well as by intersectional factors such as age, ethnicity, disability, socioeconomic status and migration status.

3.7. Currently, however, data on substance use within LGBT+ communities tends to focus on gay, bisexual and other men who have sex with men (GBMSM) and, in particular, on sexualised drug use and chemsex, rather than drug use across other LGBT+ sub-populations. Few UK-based studies examine substance use among women who have sex with women (WSW) and transgender and non-binary (TGNB) populations. As a result, existing prevalence estimates may underrepresent the scale and diversity of substance use within LGBT+ communities, particularly among TGNB people and those facing intersecting inequalities (protected characteristics as defined in the Equality Act 2010), and do not tell us about change over time or drug type.

3.8. Moreover, much of the available evidence relies on small or non-representative samples. For example, the 2024 APMS had ~20× more heterosexual participants compared to LGB+ participants (5,611 vs 278). When further broken down by gender, age group and specific drug type, sample sizes became even smaller, particularly for sexual minority populations, with many groups including fewer than 50 participants [Communication and data sharing from APMS study team, July 2026].

Prevalence of substance use among GBMSM

3.9. Data from the 2024 National Drug Treatment Monitoring System (NDTMS) collected from people accessing statutory drug and alcohol services in England show that, of those whose sexual orientation was known, GBMSM were more likely to report methamphetamine use compared with heterosexual men (67.1% (564/879) vs. 26.7% (224/870)) [NDTMS, 2025].

3.10. The Crime Survey for England and Wales (2011-2014) found a higher proportion of GBMSM reported using a Class A drug in the previous 12 months compared with heterosexual men (12% vs. 4%) [ONS 2014].

3.11. In the UK National Survey of Sexual Attitudes and Lifestyles (Natsal)-3 study (2010-2012), men who identified as gay were far more likely than heterosexual men to report drug use in the last year (46% vs. 11%; adjusted odds ratio 6.93) [Paquette et al., 2017].

3.12. Unpublished data from Natsal-4 (2022-2024) found that GBMSM had higher odds of using a Class A and/or a Class B drug in the last year compared with heterosexual men [Communication and data sharing from Natsal-4 study team, 2026].

3.13. Positive Voices, a routine national survey of people living with HIV attending outpatient care in England between April 2022-March 2023 (*n* = 4,540), found HIV positive GBMSM were more likely to have used drugs in the past 3 months compared with HIV positive heterosexual men (35% vs. 10%) [UKHSA, 2024].

3.14. Self-reported data from sexual health clinics in London collected between June 2011–July 2011 show recreational drug use (mephedrone, GHB, GBL and crystal methamphetamine (CM)) was significantly higher in GBMSM compared with other respondents [Hunter et al., 2014].

3.15. Of 418 drug samples seized from clubbers attending 'gay friendly' club venues in London between August 2006 and January 2007, 85 (37.8%) contained GHB and 140 (62.2%) contained GBL. These club venues were in the catchment area for a hospital emergency department where, during this period, 158 emergency presentations following GHB or GBL ingestion, were reported [Wood et al., 2008].

Prevalence of substance use among lesbian and bisexual women

3.16. Data from NDTMS looking at substance use among those in contact with drug and alcohol treatment services, show that, in 2024, methamphetamine use was uncommon among women (92/104,971). Of those 92 who used methamphetamine, 13 (14.2%) were WSW and 67 (72.8%) were heterosexual women [NDTMS, 2025].

3.17. Data from the APMS found that past-year drug use among sexual minority women in 2024 was more than five times that of heterosexual women. This variation was largely accounted for by differences in reported use of cannabis (27.4% sexual minority women vs 4.5% heterosexual women), MDMA (5.5% vs. 0.4%), and ketamine (6.1% vs. 0.5%). When compared to previous APMS data, point estimates of overall past-year drug use have remained stable in heterosexual women (5.8% in 2007, and 5.2% in 2024), compared to a rise in reported use in sexual minority women (18.0% in 2007, to 29.6% in 2024) [Communication and data sharing from APMS study team, 2026].

3.18. The UK Natsal-3 survey (2010–2012) received responses from 4,980 women. It was found that bisexual women had significantly higher odds

of recent drug use compared with heterosexual women (18.0% vs. 5.2%; adjusted odds ratio 3.28) [Paquette et al., 2017].

3.19. Lesbian women participating in Natsal-4 (2022–2024) had higher odds of having had sex while high/stoned on cannabis in the last year and of using a Class B drug in the last year compared with heterosexual women [Communication and data sharing from Natsal-4 study team, 2026].

3.20. Data from the US National Survey on Drug Use and Health 2015-2016 of non-incarcerated citizens aged ≥18 years old (*n* = 67,354), showed the prevalence of drug use in the last year was higher among 18– to 25-year-old lesbian/gay women compared to their heterosexual counterparts [Schuler et al., 2020].

Prevalence of substance use among TGNB individuals

3.21. The evidence of substance use among TGNB individuals is not as good quality or extensive as substance use among sexual minorities, but existing data indicate a higher prevalence of substance use among transgender women than the general population [Hoffman, 2014].

3.22. Analysis of the 2018 Global Drug Survey (43,331 cisgender women, 81,607 cisgender men, 215 transgender women, 254 transgender men and 1,241 non-binary/ other identities), found that compared to cisgender women, those identifying as non-binary/other identities were more likely to report use of all substances in the previous 12 months (adjusted odds ratio ranged from 1.66 to 2.30 across substances), apart from alcohol (lower adjusted odds ratio of 0.42 of last 12-month use [Connolly et al., 2022].

3.23. The 2022 Positive Voices Survey of HIV services in England (April 2022–March 2023, *n* = 4,540) found that 36.7% of 65 respondents who identified as trans, non-binary or in another way, had used drugs in the previous three months [UKHSA, 2024].

3.24. A recent global scoping review of 55 studies published between 2015–2022 describing substance use among TGNB youth (aged 10–24 years) found they were more likely to report alcohol and illicit-drug use than their cisgender peers [Fahey et al., 2023].

3.25. US-based studies have reported high prevalence of substance use among transgender populations [Gilbert et al., 2018; Hughto et al., 2021; Mammadli et al., 2025; Ruppert et al., 2021]. A cross-sectional study looking at data from adults aged 18 years or older enrolled in insurance plans in 2017 found alcohol and drug use disorder diagnoses were more frequent among transgender adults than cisgender adults. Of the 5,637 transgender adults included, 4.3% had a drug use disorder diagnosis and 2.6% an alcohol use disorder diagnosis compared to 1.2% and 0.9% of 46,911 cisgender adults respectively. Among transgender adults, cannabis was the most prevalent drug use

disorder diagnosis (2.1%) followed by opioids (1.3%) and cocaine (0.5%) [Hughto et al., 2021].

4. Demographic trends of substance use within the LGBT+ community

Summary

- Patterns of drug use, including preferred substance type, differ between LGBT+ sub-populations according to age, gender, sex and sexual orientation.
- Service user data from LGBT+ drug and alcohol services show that the majority of attendees at LGBT+ drug services are male, GBMSM, and between 25–45 years old.

4.1. Service data from Antidote (a London-based LGBT+ drug and alcohol service) reported 86% of 441 clients identified as male, 4% female and 4% non-binary in 2024/25. Additionally, 81% identified as gay, 6% as bisexual, 6% as queer, 1% as lesbian and 1% pansexual. The majority of attendees were aged 26-35 (38%), with 31% aged 36–45, 17% aged 46–55, 8% aged 56–65, and 1% over 66 years old [London Friend, 2026].

4.2. Peak prevalence occurs at different ages depending on the substance used. In the 2007 National Gay Men's Sex Survey (*n* = 6,155), alcohol and cannabis use peaked among men in their 20s, while cocaine, ecstasy, ketamine, GHB/GBL, and crystal methamphetamine (CM) use was most common among men in their 30s [Keogh et al., 2009].

4.3. Limited recent data on use in younger people have been published, but analysis of the 2024 APMS found that the rate of drug use in sexual minority 16–to 24- year-olds (13/43, 34.1%) was more than double that of their heterosexual peers (34/239, 15.0%) [Communication and data sharing from APMS study team, 2026].

4.4. Meta-analysis of studies between 1994–2006 reporting on the relationship between sexual orientation and adolescent substance use found that the odds of illicit substance use were, on average, 190% higher among LGB young people and around 340% higher in bisexual young people than their heterosexual peers [Marshal et al., 2008].

4.5. A meta-analysis of studies reporting on substance use among young people between January 2008–July 2024 found that sexual minority young people (under 25 years old) initiated substance use at younger ages than their heterosexual counterparts and were more likely to use all substances at a greater frequency and quantity. Polysubstance and hazardous substance use were also more common among the sexual minority group [Mereish et al, 2026].

4.6. Patterns of use also differ by gender. The 'Part of the Picture' study looked at self-reported alcohol and drug use by LGB people, with data collected through online surveys and at events between January 2009–December 2011. More women responded than men (2,274 vs 1,868) and women were more likely than men to identify as bisexual; of the respondents who identified as bisexual, 583 of these (74%) were women. When breaking down drug use by substance type, females were equally as likely to have used cannabis in the last month as males. However, males were 4× more likely to have used 'poppers' (29% vs. 7%), 3.5× more likely to use ketamine (7% vs. 2%), nearly twice as likely to use cocaine powder (10% vs. 6%), ecstasy (9% vs. 5%) and amphetamines (5% compared to 3%) and 1.5× more likely to have used non-prescribed benzodiazepines (3% vs. 2%). GHB was almost exclusively used by males [Buffin et al., 2012].

5. Patterns of specific substance use among LGBT+ communities in the UK

Summary

- Use of alcohol, cannabis, cocaine, ketamine, MDMA, alkyl nitrites ('poppers'), GHB/GBL, (crystal) methamphetamine and mephedrone are widely reported among LGBT+ communities.
- Most of the available data are focused on GBMSM with limited data on WSW and TGNB populations.

Alcohol

5.1. Alcohol use by LGBT+ people is widely reported across several surveys. LGBT+ individuals have been found to be more likely than their heterosexual counterparts to exceed national alcohol consumption guidelines, both in terms of the number of units consumed and the frequency of consumption [Meads et al., 2023; IAS, 2021].

5.2. A 2017 study using data from cross-sectional household surveys to analyse alcohol use and sexual orientation among nearly 44,000 adults in England found that GBMSM individuals were twice as likely to engage in hazardous drinking compared to heterosexual men, whereas bisexual women were three times as likely as heterosexual women to engage in hazardous drinking [Shahab et al., 2017].

5.3. The 'Part of the Picture' study looking at self-reported alcohol and drug use by LGB people (January 2009–December 2011) found that a third of men (34%, 635/1,868) and almost one third of women (29%, 659/2,274) reported binge drinking at least once or twice a week [Buffin et al., 2012].

5.4. Between February and April 2017, 5,375 LGBT people across England, Scotland and Wales completed an online questionnaire about their life in Britain today. One in five (20%) GBMSM respondents reported drinking alcohol almost every day over the last year compared to 13% of LGBT women and 11% of non-binary people [Bachmann, 2019].

5.5. In a 2022 cross-sectional survey of 565 trans, non-binary, genderqueer, or gender non-conforming individuals, 465 (82.3%) reported current alcohol use [Connolly et al., 2023]. A second survey study of 462 UK-based trans and non-binary people reported alcohol use was 'hazardous' or 'harmful' in 57.1% of participants and high-risk in 23.2% [Connolly et al., 2024a, 2024b].

Cannabis

5.6. Cannabis was one of the most commonly used substances across all LGBT+ respondents in identified studies. In the two identified UK studies, the range of use over the preceding 12 months was wide (28–54%) [Keogh et al., 2009; Murray, 2023]. These differences may reflect the time between the studies.

5.7. The 2025 CSEW reported cannabis use among 5.8% (842/14,774) of heterosexual respondents, 13.9% (49/352) of gay/lesbian respondents, 22.4% (121/541) of bisexual respondents and 14.4% (18/125) of 'other' respondents [ONS, 2025b].

5.8. In GBMSM groups, a UK national online survey of 15,360 men from 2014 found almost half (48.6%) of respondents reported lifetime cannabis use, with a quarter (25.9%) using it in the past 12 months and 4.3% in the 24 hours prior to completing the survey [Hickson et al., 2014]. The European MSM Internet Survey (EMIS)-2017 study found lifetime use of cannabis among 126,258 GBMSM respondents was 39.3%, with 8.4% using it in the past 7 days [ECDC, 2019].

5.9. Data from the 2024 APMS suggest that 21.1% (44/278) of sexual minority adults reported cannabis use compared to 7.8% (338/5,616) of heterosexual adults [Communication and data sharing from APMS study team, 2026].

5.10. For WSW, Natsal-4 data (2022–2024) show higher odds of cannabis use during sex when compared to their heterosexual counterparts [Communication and data sharing from Natsal-4 study team, 2026].

5.11. Data gathered from five Health and Social Care Trust areas in Northern Ireland (NI) between January 2024 and July 2025 (n = 232) found that cannabis use was highest among bisexual (53%), followed by lesbian (32%) and gay (15%) participants [Spratt and Harris, 2026].

Cocaine

5.12. Multiple studies reported more frequent use of cocaine in GBMSM and WSW than heterosexual respondents [Heinsbroek et al., 2018; Communication and data sharing from Natsal-4 study team 2026; ACMD, 2015].

5.13. The 2025 CSEW reported powder cocaine use among 1.9% (281/14,774) of heterosexual respondents, 5.7% (20/352) of gay/lesbian respondents, 7.2% (39/541) of bisexual respondents and 1.0% (1/125) of 'other' respondents [ONS, 2025b].

5.14. The 2017 EMIS reported use of cocaine ever among 18.8% of 126,153 respondents, with 1.9% reporting use in the last 7 days [ECDC, 2019]. In a 2025 survey, over half (54%) of 334 predominantly GBMSM respondents (89%) reported cocaine use in the previous 12 months [London Friend, 2026].

5.15. Among respondents in a London LGBT+ night club study conducted in July 2010, cocaine was the second most used drug over lifetime use [Measham et al., 2011].

5.16. Survey data from five Health and Social Care Trust areas in NI (January 2024 to July 2025; *n* = 232) showed that cocaine use was highest among gay (69%), followed by bisexual (19%) and lesbian (12%) participants [Spratt and Harris, 2026].

Ketamine

5.17. More detail on the prevalence of ketamine use can be found in the 2026 ACMD Report [ACMD, 2026b]. In brief, LGBT+ people are more likely to report ketamine use than the general population and ketamine may be a component of drug use during chemsex parties [ACMD, 2026b].

5.18. The 2025 CSEW reported ketamine use among 0.6% (*n* = 14,774) of heterosexual respondents, 1.5% (*n* = 352) of gay/lesbian respondents, 5.6% (*n* = 541) of bisexual respondents and 1.2% (*n* = 125) of 'other' [ONS, 2025b].

5.19. Survey results from the 2024 APMS showed that ketamine use was reported by 3.6% (6/278) of sexual minority adults compared to 0.8% (22/5,616) of heterosexual adults [Communication and data sharing from APMS study team, July 2026].

5.20. A 2025 London-based survey of 334 predominantly GBMSM (89%) individuals found that 51% of respondents reported ketamine use in the previous 12 months [London Friend, 2026].

5.21. Specific data on the use of ketamine among WSW and TGNB respondents were lacking.

MDMA

5.22. MDMA use across studies was predominantly reported in its tablet form, ecstasy. The 2014 UK Gay Men's Sex Survey (GMSS) (*n* = 15,360) found that 0.3% and 15.3% of respondents had used ecstasy in the previous 24 hours and 12 months respectively [Hickson et al., 2014].

5.23. The 2024 APMS found that MDMA use was reported by 5.8% (12/278) of sexual minority adults compared to 1.1% (38/5,616) heterosexual adults [Communication and data sharing from APMS study team, July 2026].

Alkyl Nitrites ('poppers')

5.24. Use of alkyl nitrites ('poppers') by GBMSM is common [ACMD, 2024] with usage in the past year ranging from 31-42% (2007-2022) [Guasp, 2013; Murray et al., 2023; Keogh et al., 2009]. Alkyl nitrites were the most commonly used substance in the 2022 Positive Voices survey (*n* = 4,540) [UKHSA, 2024].

5.25. In a 2025 London-based survey, 65% of the 334 predominantly GBMSM respondents (89%) reported using 'poppers' in the last 12 months [London Friend, 2026].

5.26. Data gathered from five Health and Social Care Trust areas in NI from January 2024 and July 2025 (*n* = 232), found gay participants were most likely to use 'poppers' (57%), followed by bisexual (38%) and lesbian participants (5%) [Spratt and Harris, 2026].

GHB/GBL

5.27. GHB/GBL use among GBMSM is well documented [ACMD, 2020], with little data existing on its use by WSW and TGNB.

5.28. The 2014 GMSS online survey of 15,360 GBMSM looked at GHB/GBL use by respondents over multiple timeframes; in the last 24 hours (0.5%), in the last 12 months (6.5%), and lifetime use (12.5%). Use was significantly higher in London (8.2%) compared to the rest of England (1.5%) [Hickson et al., 2014].

5.29. A survey at a London night club in 2010 found 34% of 308 respondents reported lifetime use of GHB [Measham et al., 2011]. A second cohort of follow-up night club surveys conducted in July 2011 found 24% of 315 attendees had taken GHB or GBL on the night in question [Wood et al., 2012].

5.30. In a single-site Irish study conducted over a six-week period in 2016 with 510 respondents, 27% had engaged in chemsex drug use in the previous 12 months with over half (57%) of those reporting GHB/GBL use in that timeframe [Glynn et al., 2018].

5.31. European data on GHB/GBL use identifies similar trends. In the EMIS-2017 conducted across 38 countries, including the UK, 10.2% of 113,272 respondents reported using GHB/GBL [ECDC, 2019]. Data from EURO-DEN, which examines acute toxicity presentations to emergency departments across European sites, found that 91.8% of the 5,529 acute toxicity presentations involving GHB/GBL occurred in three centres: London, Oslo and Barcelona [Dines et al., 2015].

5.32. In 2020, the US National Survey on Drug Use and Health estimated the crude prevalence of GHB use in different age groups. Among people aged 12 or older, 0.1% (183,000 people) used GHB in the past year. In addition, 0.1% of 18– to 25- year-olds (24,000 people) and those aged 26 or older (158,000) had each used GHB in the past year [SAMHSA, 2021]. In New York City, a study investigating the sexual effects of club drug use between February 2001-October 2002 found 31.8% (*n* = 198) of the participants reported GHB use [Palamar et al., 2014].

Crystal Methamphetamine (CM)

5.33. In the UK, CM use is commonly seen in GBMSM communities. A 2011 questionnaire-based study of participants recruited through sexual health clinics in London found 16.9% of GBMSM respondents (*n* = 254) reported CM use compared to 2.9% of non-GBMSM male participants (*n* = 475) [Hunter et al., 2014]. The 2013 Gay and Bisexual Men's Health Survey across Britain (*n* = 6,861) found 2.0% of GBMSM had taken CM in the last year compared to less than 1.0% of men in general [Guasp, 2013].

5.34. CM use in the UK predominates in urban regions. In a survey collecting data from males over 14 years old, living in the UK, and reporting sex with a man in the previous year and/or a gay, bisexual or other non-heterosexual identity, 4.7% (290/6,155) reported CM use in the past year. CM use was highest in London (7.8%, 155/1,986) followed by Wales (4.8%, 12/248), Mid/East England (3.5%, 42/1,210), South England (3.3%, 41/1,225), North England (2.8%, 32/1,126), and Scotland and Northern Ireland (2.2%, 8/360) [Bonell et al., 2010].

5.35. The GMSS 2014 study (*n* = 15,360) found 3.8% of responders reported CM use in the past 12 months and 8.3% reported lifetime use in 2014. Again, use was higher among London respondents (11.6%) compared to the rest of England (1%) [Hickson et al., 2014].

5.36. A retrospective case notes review in two South London sexual health clinics over a 6-month period between June 2014-January 2015 (*n* = 818) found 46% of respondents reported CM use [Hegazi et al., 2017]. In social and clubbing venues, the reported use among attendees was higher with 65% of 308 attendees in July 2010 reporting lifetime use of CM [Measham et al., 2011].

5.37. European data from the EMIS-2017, which included UK respondents, showed 1.4% of 126,148 respondents had used CM in the last four weeks and 3.6% had used CM in the last year [ECDC, 2019].

5.38. Internationally, an American mixed methods study looking at sexual effects of club drug use among GBMSM between February 2001-October 2002 found 65.7% of 198 respondents reported using CM [Palamar et al., 2014]. A study from Chicago and Los Angeles reported 15.8% of those recently diagnosed with HIV who used drugs during sex were using CM (*n* = 111) [Carey et al., 2009].

5.39. A multi-country online survey conducted across Asia of 10,861 GBMSM participants, found the second most used stimulant used in the past 6 months was CM (4%) after ecstasy (8.1%) [Wei et al., 2012].

Mephedrone

5.40. The 2014 UK Gay Men's Sex Survey (GMSS) found 0.8% of 15,360 participants had used mephedrone in the last 24 hours, 10.9% had used it in the past 12 months, and 16.5% had used it ever [Hickson et al., 2014].

5.41. In a London based survey performed in July 2010 at two 'LGBT+ friendly' venues, lifetime use of mephedrone among 308 participants was 54% [Measham et al., 2011]. A second snapshot survey of drug use at two 'gay friendly' venues in South London (July 2011; *n* = 315) found mephedrone was the most frequently used drug on the evening of the survey, with 41% reporting that they had taken and/or were planning to take mephedrone that evening [Wood et al., 2012].

5.42. A more recent survey of 334 LGBT+ respondents with experience of drug use and/or chemsex in London reported a decrease in recent mephedrone use compared to the 12 months prior [London Friend, 2026].

6. Chemsex

Summary

- Chemsex is a term used to describe sex occurring under the influence of certain drugs (typically GHB/GBL, CM and mephedrone) usually seen in GBMSM, although it is increasingly being reported in other LGBT+ groups and heterosexual cisgender men and women.
- UK prevalence appears higher than in many other European countries, particularly in urban centres such as London, Manchester, and Brighton.
- Chemsex related drug use is associated with significant levels of polysubstance use.

6.1. Chemsex is a term within the GBMSM community and describes sex occurring under the influence of drugs (most typically GHB/GBL, CM and mephedrone) taken immediately preceding and/or during sex for the purpose of enhancing and/or sustaining the sexual experience. This occurs through increased sexual arousal and performance, emotional connectedness, disinhibition, enhanced stamina, and a reduction of anxiety or inhibition. This phenomenon is usually reported as separate from sexualised drug use where other drugs, particularly alcohol, cocaine and ketamine, are used. However, the terminology is often used interchangeably within the literature.

6.2. Chemsex can take place in various locations with different levels of 'access' such as anonymous sessions, semi-closed parties among networks of friends, private residential homes, saunas or other 'sex-on-premises' venues [Santoro et al., 2020] and is frequently facilitated by location-based social networking apps [Hillier et al., 2024].

6.3. Many studies that report survey-based data on chemsex and related drug use do not clarify whether respondents used these drugs during sex or in the hours beforehand. This distinction is particularly important in surveys conducted in clubs or social settings, where reported drug use on a given night may not necessarily be linked to sexual activity.

Prevalence of chemsex drug use

6.4. The use of chemsex drugs is usually seen in GBMSM, though it is increasingly being reported in other LGBT+ groups and heterosexual cisgender men and women [Gooden and Whitlock 2025, ACMD call for evidence 2025, LGBT Foundation submission, 2026].

6.5. National bio-behaviour data of people who inject drugs in England, Wales and Northern Ireland (2013-2016) suggests GBMSM (*n* = 299) were more likely than heterosexual men (*n* = 3,215) to use chemsex associated substances such as mephedrone and ketamine [Heinsbroek et al., 2018]. This is also reflected in more recent data (2018-2023) [Communication from UKHSA, 2026].

6.6. Unpublished data from Natsal-4 (2022-2024) suggest that men who identified as gay, and women who identified as bisexual or another sexual minority, had higher odds of reporting practising chemsex or sexualised drug use compared with their heterosexual counterparts [Communication and data sharing from Natsal-4 study team, 2026].

6.7. Data from Antidote found that, in 2024/25, 61% of 441 service users reported drug use in a sexual context [London Friend, 2026]. The 2022 Positive Voices survey of people living with HIV accessing care (*n* = 4,540) found a slight increase in chemsex prevalence among GBMSM with 14.1% reporting chemsex in the previous 3 months in 2022, compared to 13.1% in 2017. Of note, 24.8% of chemsex users had

'slammed' (injected) drugs in the previous three months and 23.2% of people who ever injected drugs engaged in chemsex [UKHSA, 2024].

6.8. Service data from the LGBT Foundation on individuals accessing their services between January 2022-August 2025 found the rate of chemsex substance use (mephedrone, GHB, CM) to be 9.1% (157/1,730) among men (including transgender men), 1.3% (10/766) among women (including transgender women), 2.6% (9/341) among non-binary individuals and 3.4% (5/146) among those identifying their gender in another way [ACMD call for evidence 2025, LGBT Foundation submission, 2026].

6.9. The LGBT Foundation also recorded data on the age of individuals reporting use of chemsex substances accessing their services between January 2022-August 2025. Of those accessing their services, individuals aged 36-45 showed the greatest use of chemsex substances (11%, 76/716) followed by individuals aged 46-55 (9%, 24/266) and 26-35 (5%, 70/1,446) [ACMD call for evidence 2025, LGBT Foundation submission, 2026].

6.10. A cross-sectional retrospective analysis of case notes of GBMSM accessing a South London open access sexual health service between 2014-2017 found that 407/2,174 (19%) disclosed chemsex participation [Pakianathan et al., 2018].

6.11. Predominantly reported in urban centres, a European study of 55,446 MSM living in 44 urban centres found that, in 2010, the highest reported use of chemsex associated drugs across Europe was in the UK (Brighton 16.3%, Manchester 15.5%, and London 13.2%). Usage was at least double that reported in other European cities (Barcelona 7.9%, Berlin 5.3%, and Sofia 0.4%) [Schmidt et al., 2016].

6.12. In Ireland, a single-site study at a GBMSM-specific sexual health clinic over a six-week period in 2016 found that 27% of 510 respondents had engaged in chemsex within the previous 12 months [Glynn et al., 2018].

6.13. In Amsterdam, a focused survey in a sexually transmitted infection (STI) clinic during three periods in 2008/2009 identified sex-related drug use in 51.6% of GBMSM (*n* = 673) compared to 22.6% of heterosexual men (*n* = 961) [Heiligenberg, 2012].

6.14. During the COVID-19 pandemic, chemsex related substance use continued and for some respondents, use increased [Connolly et al., 2023].

Polysubstance use

6.15. Polysubstance use is the simultaneous or sequential use of multiple substances during a single episode of use. This can involve using additional substances to counteract the side effects of other drugs

taken. Polysubstance use is widely reported among certain LGBT+ communities notably, those partaking in chemsex, with users often combining three to four substances per event [Platteau et al., 2025]. Different substances may be taken by a variety of different routes (e.g. nasal insufflation (“snorting”), ingestion or injection). The frequency of use by different routes may vary depending on the use setting.

6.16. The Antiretrovirals, Sexual Transmission Risk and Attitudes (ASTRA) study examined self-reported drug use among 2,248 GBMSM living with HIV in the UK between February 2011-December 2012. In the 1,138 individuals who had used drugs, 529 (47%) had used three or more and 241 (21%) had used five or more over the previous three months [Daskalopoulou et al., 2014]. In GBMSM attending two sexual health clinics between June 2014-January 2015, 67% of drug use assessments recorded polysubstance use [Hegazi et al., 2017].

6.17. Venue based surveys across two ‘gay friendly’ South London dance clubs in July 2011 identified similar polysubstance trends. Of 315 participants, 63% used, or were planning to use, more than one substance on the night of the survey [Wood et al., 2012]. Surveys carried out in 2002-2005 at sites including gyms (*n* = 1,592) and sexual health clinics/HIV treatment centres (*n* = 654), found over 80% of those reporting CM use had taken other recreational drugs at the same time [Bolding et al., 2006].

6.18. A cross-sectional retrospective analysis of case notes of GBMSM accessing a South London open access sexual health service between 2014-2017 found that polydrug use was common among those disclosing chemsex participation (74%, 301/407) [Pakianathan et al., 2018].

6.19. This trend was seen beyond the UK; 24% (51/209) of GBMSM respondents at Dutch STI clinics in 2018 reported using five or more different drugs in the previous six months [Evers et al., 2020]. In the 2021 USA National Survey on Drug Use and Health which examined polysubstance use by sexual identity, it was found that use of two drugs or three or more drugs was 19.1% and 11.3% among heterosexuals (*n* = 41,748), 25.7% and 25.1% among gay/lesbian respondents (*n* = 1,135), and 24.7% and 34.2% among bisexuals (*n* = 2,365) respectively [Lee et al., 2023]. This pattern of polysubstance use has been repeatedly seen in American studies looking at the use of chemsex associated substances among GBMSM [Forrest et al., 2010; Fernandez, 2005].

6.20. Analysis of data from the 2004 National Drug Strategy Household Survey (a multistage probability sample of Australians aged 14 years or older) suggested that, compared to non-users, GHB and ketamine users were more likely to report the recent use of a wide range of other drugs. Up to two thirds of users will typically take other drugs alongside GHB/GBL [Degenhardt and Dunn, 2008].

7. Physical and mental health harms

Summary

- Despite being a minority practice among a minority population, chemsex is disproportionately associated with significant and complex harms across physical health, sexual health, mental health and social harms.
- Harms are driven by polysubstance use, overdose risk, sexual health risks (including STI and blood borne virus (BBV) (e.g. Hepatitis B, Hepatitis C and HIV) acquisition), mental ill-health, impaired consent, sexual violence, exploitation, and increasing involvement with criminal justice systems.
- Mortality associated with chemsex is probably underreported because sexual orientation, gender identity, and the sexualised context of drug use are not routinely recorded in national mortality datasets.

7.1. Chemsex is a minority practice among a minority population (predominantly GBMSM), but it is disproportionately associated with significant and complex harms. While the drugs used have perceived benefits these can be accompanied by serious psychological and social harms, including risk-taking behaviours, reduced protective decision-making, and increased psychological vulnerability [Gilbart et al., 2015; Hibbert et al., 2021; ACMD, 2020; LGBT Foundation, 2019].

7.2. Drug related harms can be specific to each substance and its pharmacology, the method of administration, and to other practices associated with drug taking (e.g. high-risk, condomless sexual sessions with multiple partners).

7.3. Detail on the more general physical, social and mental harms associated with individual substances prevalent among LGBT+ communities can be found in previous ACMD reports (Table 1).

Harms associated with polysubstance use

7.4. Polysubstance use increases the risk of toxicity between recreational substances, prescribed medication, and drugs available over the counter [EUDA, 2026].

7.5. Among 83 decedents identified as LGBT+ and dying due to drug related causes in the UK between 1997-2024, multiple drug toxicity was implicated in just over half of cases (n = 42, 50.6%) and the two most common illicit drug groups implicated in death were opioids (n = 31, 37.3%) and GHB and related substances (n = 14, 16.9%) [Roberts et al., 2026].

7.6. Of 505 people admitted to an emergency department in Barcelona with GHB overdose (two thirds male) between 2000-2007, 76% had consumed other drugs: ethanol (64%), amphetamines and derivates

(30%), cocaine (28%), ketamine (11%), cannabis (9%) and others (5%) [Galicia et al., 2011]. Additional substances were also reported in two thirds of 54 confirmed cases of GHB overdose attending an emergency department in Washington State over a 12-month period [Couper et al., 2004].

7.7. Antiretrovirals (ART) used for HIV prevention and treatment may be impacted by polysubstance use. Recreational drug use has consistently been linked to lower ART adherence, with even lower levels among poly-drug users [NEPTUNE, 2016; Viamonte et al., 2022].

Chemsex related physical harms

7.8. Physical harms from chemsex related substances can take many forms, but are often associated with administration injuries, therapeutic dose-windows, and behaviour associated with taking these drugs. They include [Bourne et al., 2015; Hillier et al., 2024; Bouëdec et al., 2025; Bracchi et al., 2015]:

- ***injecting injuries*** including physical trauma and abscess formation;
- ***elevated risk of overdose*** particularly with GHB/GBL due to narrow dose-response margins;
- ***rectal trauma and penile abrasions*** due to the length of sexual encounters.

7.9. CM use among GBMSM participating in chemsex has been associated with higher risk behaviours (injecting drugs, group sex) as well as STI acquisition and other health and social consequences (negative mental health impacts, overdosing, time off work, relationship breakdown, financial impacts, involvement with the criminal justice system and hospital admission) compared to GBMSM not using CM [Pakianathan et al., 2018].

7.10. NDTMS data recorded 196 deaths due to amphetamines in 2023 compared to 56 deaths in 2011. When specifically examined for CM, 42 deaths occurred in 2024 compared to only 2 deaths in 2011. There were 24 deaths due to GHB in 2023 compared to 19 in 2011. Data on drug related deaths from NDTMS cannot be differentiated by sexual orientation or gender identity, so it is not possible to determine the number of deaths that were LGBT+ individuals, or if this had changed over time. [NDTMS, 2024].

7.11. Coroners do not routinely record sexual orientation or transgender status within coronial records submitted to the National Programme on Substance Use Mortality (NPSUM). However, NPSUM datasets between 1997-2024 have recorded consistent numbers of drug related deaths each year among LGBT+ individuals in the UK, results likely representing conservative estimates. Among the 83 LGBT+ individuals who died from drug related causes during this period, 21 deaths

(25.3%) occurred in the context of sexualised drug use [Roberts et al., 2026].

Chemsex related sexual health harms

7.12. The association between drug use, prolonged sexual encounters with multiple partners, and acquisition of STIs and bloodborne viruses (BBV) is well documented.

7.13. Injecting drugs ('slamming') is associated with an increased risk of BBV acquisition [ECDC, 2019; Kirby and Thornber-Dunwell, 2013; Hunter et al., 2014; Theodore et al., 2014; Bourne, 2018; Frankis et al., 2018; Hammoud et al., 2018; O'Reilly, 2018; ACMD, 2020].

7.14. While prevention methods like doxycycline post-exposure prophylaxis (Doxy-PEP) are expected to reduce the incidence rates of chlamydia and syphilis, chemsex groups often involve dense sexual networks that provide an ideal environment for STI transmission.

7.15. GBMSM living with HIV in the UK are more likely to use drugs than those not diagnosed with HIV and report higher levels of sexualised drug use, drug injecting, and use of chemsex related drugs [NEPTUNE, 2016; Edmundson et al., 2018; Hickson et al., 2009; Bolding et al., 2006]. A similar trend has been documented elsewhere, including Australia [Takeuchi et al., 2024], Latin America [Lisboa et al., 2023], Asia [Wei et al., 2012] and the USA [Forrest et al., 2010; Schwarcz et al., 2007; Whittington et al., 2002].

7.16. A combination of access to testing and widespread availability of ART has significantly reduced the level of detectable HIV in the population with resultant reduced levels of transmission. When combined with the introduction of HIV pre-exposure prophylaxis (PrEP), this has significantly reduced the incidence of HIV in the UK. However, prolonged episodes of chemsex and ongoing use of drugs may impact adherence to prescribed medication including ART and PrEP, thus increasing the risk of HIV acquisition [NEPTUNE, 2016; Viamonte et al., 2022].

Chemsex related mental health harms

7.17. Minority stress (stress caused by discrimination, prejudice, homo/bi/trans-phobia) and mental ill-health have been identified as key contributors to higher rates of drug use among LGBT+ individuals [LGBT Foundation, 2019, 2024, Murray et al., 2023; Meyer, 2003; Krueger et al., 2020; Hillyard et al., 2026a]. For many, substance use functions as a coping or escape strategy.

7.18. TGNB populations face vulnerability with rising transphobia and hostile policy climates in the UK and US being suggested to widen drug related disparities [Connolly et al., 2025].

7.19. There is a strong association between chemsex and anxiety, depression, and compulsive sexual behaviour [Hibbert et al., 2021]. As part of the Chemsex Study in 2014, some men reported problems relating to paranoia, anxiety or aggression, and several experienced acute attacks of mania or psychotic episodes requiring medical intervention [Bourne et al., 2014].

7.20. After chemsex events, many individuals experience emotional crash states, including depression, anxiety, psychosis, dissociation, and suicidal ideation [Strasser et al., 2023, Del Pozo-Herce' et al., 2024]. This may drive use of post-chemsex prescription medications with strongly sedating or antipsychotic activities e.g. tapentadol, pregabalin, quetiapine, or olanzapine which further increases the risks of overdose or dependence.

Chemsex related social harms

7.21. A growing body of UK evidence demonstrates that LGBT+ communities experience disproportionately high levels of social harm associated with illicit drug use and chemsex related practices. A complex social harm profile associated with chemsex routinely presents across health, social care and criminal justice settings [Hillier et al., 2024].

7.22. The 2024 'No One Blooms in Isolation' report from the LGBT Foundation describes how LGBT+ individuals experience cumulative harms before seeking formal treatment reflecting both stigma-related barriers and gaps in inclusive service provision [LGBT Foundation, 2024].

7.23. The social harms and safeguarding issues associated with chemsex include:

- acute behavioural disturbance;
- sexual assault and sexual violence;
- relationship breakdown;
- social isolation and stigma;
- contact with the criminal justice system;
- housing instability in some groups.

7.24. Sexual assault and sexualised violence are commonly disclosed to specialist support agencies as chemsex associated harms. While people engaging in chemsex may consent to the initial taking of drugs, the effects of the drugs (drowsiness, reduced consciousness, and coma) reduce the ability to subsequently consent and therefore, individuals are vulnerable to being the victim of non-consensual sex or sexual assault and rape. Chemsex itself is not a precursor to any unwanted sexual attention or activity, but the physical and psychological impact of the drugs used, the situational mindset of the individual and the setting or environment the individual is in can often create an environment for sexual assault [SUSU, 2025].

7.25. GHB/GBL use is particularly associated with non-consensual sex, and drug facilitated sexual assault, often through spiking of drinks [Németh et al., 2010]. Loss of consciousness for short periods during sex after using GHB/GBL appears to be common and has been reported by some individuals to be considered ‘relatively normal’ [Corkery et al., 2018].

7.26. Within the context of a chemsex study, 3/30 gay men aged 21-53 reported being a victim of non-consensual sex [Bourne et al, 2015]. There may be consent issues if someone loses consciousness during sex, and a study conducted through an MSM-specific sexual health clinic, found 17% of 510 participants in 2016 reported loss of consciousness during sex and 6% reported their partner losing consciousness during sex [Glynn et al., 2018].

7.27. Drug use in a sexualised context can impact the ability to engage in sexual activity sober with reports of individuals becoming reliant on drugs and finding it difficult to have sex without them [Bourne et al., 2014; Weatherburn et al., 2017].

7.28. Increasing numbers of individuals in UK prisons have offences associated with, or occurring within the context of, chemsex [Hillier et al., 2024]. In 2018, Project Sagamore was established as a joint Metropolitan Police Service (MPS) and His Majesty's Prison and Probation Service response to crime-related risk, harm, and vulnerability in the chemsex context. Reports from MPS show an increase in chemsex related offences, increasing from 19 in 2018 to 363 in 2023, with approximately three suspected chemsex context deaths per month in London alone [College of Policing, 2024]. It is not possible to know if this increase could be due to greater focus by the police on this and/or an increase in prevalence.

7.29. In the UK, GHB related substances (GHBRS) have been used to facilitate serious crimes, including murder, rape, sexual assault and robbery. Some of these crimes occur in a chemsex context, however, this is not exclusively the case. A number of UK criminal cases where GHB has been linked to serious crimes are outlined in the ACMD GHB report including the cases of Stephen Port, Gerald Matovu and Reynhard Sinaga [Pettigrew, 2018; ACMD 2020].

8. Current treatment services and interventions

Summary

- Current responses to drug use and chemsex related harms in LGBT+ communities are fragmented and inconsistent, despite harms often spanning sexual health, mental health, substance use and safeguarding services.
- There are limited data on effective interventions, variable processes across the UK and a reliance on local interventions limit service effectiveness.
- Strengthening system integration, workforce capability, peer-led provision, and national standards will support prevention, treatment, and harm reduction goals.

8.1. The harms associated with drug use in LGBT+ communities, including chemsex, occur at the intersection of sexual health, mental health and substance use systems.

8.2. Harms frequently present across multiple systems simultaneously, including sexual health, emergency care, mental health, acute services, substance use systems and safeguarding and may escalate quickly where dependency develops [ACMD, 2020; Hibbert et al., 2021]. Yet, commissioning responses remain fragmented and inconsistent across England. As such, individuals frequently move between services without coordinated care planning. This undermines continuity of treatment and engagement.

8.3. National monitoring and routine data collection remain incomplete across clinical and community settings [OHID, 2023; ACMD, 2020]. The lack of data on prevalence, treatment outcomes, and unmet needs limits the ability to plan and evaluate future strategies. Similarly, there is limited evidence within a UK context of effective interventions and commissioned services to address the associated harms. That said, services that are culturally tailored, peer-led, and integrated across sectors are likely to improve engagement and reduce risk [Hillier et al., 2024; Hillyard et al., 2026b].

8.4. Sexual health services often act as the primary point of disclosure and entry into care, particularly for individuals not engaged with mainstream drug services [Bourne et al., 2015]. Sexual health services collect data for the Genitourinary Medicine Clinic Activity Dataset (GUMCAD), a mandatory reporting system providing data on sexual health services, helping to monitor trends in STI diagnoses, identify inequalities in sexual health, and measure the success or impact of service delivery. GUMCAD-3 (the current iteration of GUMCAD) does have a coding framework for recording drug use, including chemsex

drugs, and drug use before or during sex, however, these data are inconsistently recorded and are often incomplete.

8.5. Current service provision is variable across England, reflecting differences in local commissioning priorities, resource allocation, and workforce capability as well as fragmented commissioning responsibilities with services relevant to chemsex spanning different organisations e.g. integrated care boards (ICBs), local authorities and healthcare providers [ACMD, 2020]. While a number of areas have developed innovative and effective models of care, (e.g. Forward Leeds, MESMAC Yorkshire and SAFER 23-24 launched by Croydon Council) there are no national commissioning specifications, outcome measures, or workforce competency frameworks for chemsex services. Many areas depend on local innovation, short-term funding streams or the presence of specialist clinical or voluntary sector 'champions'. Reliance on single specialist practitioners or small teams creates service fragility and increases risk of staff burnout, undermining treatment system resilience.

8.6. Chemsex and the use of these drugs should be treated as a system-level commissioning issue rather than a niche specialist service [ACMD, 2020]. Earlier engagement is likely to reduce morbidity, mortality and repeated use of emergency services. Untreated dependency is associated with episodes of poor mental health which can result in severe anxiety and depression, suicidal ideation and crisis mental health admissions. Integrated psychological intervention reduces repeat crisis presentations and associated high-cost inpatient care [Hibbert et al., 2021; Maxwell et al., 2019].

8.7. Effective services typically include:

- integrated pathways between sexual health, mental health, and substance use services [ACMD, 2020];
- co-location or shared care protocols;
- peer-led, outreach and engagement [WHO, 2020];
- trauma-informed, sex-positive approaches [Hibbert et al., 2021];
- targeted harm reduction (safer injecting kits, condoms, naloxone, drug testing);
- digital outreach via dating and social platforms [Bourne et al., 2015; ACMD, 2020].

8.8. Alongside the expansion of HIV peer support offered in clinic as part of the national rollout of HIV Emergency Department Opt-out Testing, there is scope to ensure that peer navigators and peer support workers are appropriately trained and skilled around the use of drugs and alcohol in relation to sex and HIV.

9. Barriers to treatment

Summary

- LGBT+ people face significant barriers to accessing drug and alcohol treatment including stigma, discrimination, previous negative experiences, and a lack of culturally competent support.
- Mainstream services are often perceived as ill-equipped to meet LGBT+ needs and TGNB people face additional challenges, including misgendering, exclusionary service practices, and limited recognition of their specific experiences and stressors.
- These barriers can discourage help-seeking, reduce disclosure of substance use issues, and contribute to poorer outcomes.
- Improving access requires culturally competent, inclusive services, co-designed with LGBT+ communities.

9.1. LGBT+ people face structural and interpersonal barriers to accessing treatment. Negative healthcare encounters are frequent, and many receive poorer-quality care than heterosexual people [Hillyard et al., 2026a, Hillyard et al., 2026b].

9.2. Mainstream drug and alcohol services are perceived as judgemental, lacking cultural competence and unable to address sexuality, gender and substance use together (Annex B) [Murray et al., 2023; ACMD call for evidence 2025; Hillyard et al., 2026a]. This is particularly relevant for chemsex, and sexualised drug use support, where participants describe providers as lacking basic familiarity with the drugs, practices, and associated risks [LGBT Foundation, 2019, 2024].

9.3. LGBT+ people report that their first instinct is to seek help from LGBT+-specific, peer-led or community-run services because they fear stereotyping, moral judgement or breaches of privacy [LGBT Foundation, 2019; LGBT Foundation, 2024]. Peer-based or LGBT+-specific support is seen as a safer and more validating setting [Kia et al., 2023].

9.4. The lack of sexual and gender minority-specific knowledge and 'cultural competence' may contribute to experiences of stigma, discrimination and homophobia or transphobia. Patient experiences of misgendering, inappropriate questions, or the dismissal of their partners, families or social networks delay help seeking behaviour and lead to service users minimising disclosure, or not attending specialist services [LGBT Foundation, 2019; Domiva et al., 2022; Mental Health Research UK, 2025]. Many services do not routinely address issues relating to sexuality and sexual practices, disregarding that a person's drug use can be tightly intertwined with sexual identity and chemsex culture.

9.5. Drinkaware's 'Out in the Open' report, 2024, found that LGBT+ respondents were more likely than cis-heterosexual respondents to

report discrimination in healthcare and local services and correlated this with both heavier drinking and higher psychological distress, suggesting a feedback loop between discrimination, distress, substance use and reduced help-seeking [Drinkaware, 2024].

9.6. Mainstream programmes rarely address TGNB-specific stressors such as family rejection, violence, minority stress and gender dysphoria. Furthermore, refusal of care and rigid binary service protocols worsen the experience for users of these services [Hughto et al., 2024]. Facilities often lack inclusive spaces, fail to accommodate chosen names and gender markers, and clinicians report limited guidance on TGNB-specific care [Mammadli et al., 2025].

9.7. Service data from Antidote highlights the value placed on LGBT+ specific support with 78% of 334 respondents saying they viewed LGBT+ specific support as important and 85% saying they would like support from LGBT+ peers [London Friend, 2026]. This was further supported by responses to the ACMD's 2025 call for evidence (Annex B).

9.8. Improving access requires culturally competent practice, inclusive service design, visible cues of safety, meaningful co-production with LGBT+ communities and dedicated action on stigma and discrimination across healthcare and social-care systems.

10. Conclusions

10.1. Drug use among LGBT+ communities, and particularly chemsex, represents a complex and evolving public health challenge. Current commissioning arrangements are fragmented, inconsistently resourced, and insufficiently evidence driven. Without coordinated commissioning, drug related harm and health inequalities will increase, opportunities for early intervention will be missed, acute healthcare demand will rise, and prevention investment will remain inefficient.

10.2. Strengthening system integration, workforce capability, peer-led provision, and national standards will support prevention, treatment, and harm reduction goals.

10.3. Drug treatment services are consistently shown to deliver a positive return on investment due to reduced crime, healthcare use, and social harm. Extending this principle to chemsex specific early intervention is highly likely to be cost-effective, particularly where targeted at high-prevalence urban areas.

10.4. Addressing these commissioning gaps will improve health outcomes, reduce inequalities, and enhance the effectiveness of drug treatment and recovery systems in the UK.

11. Recommendations

Recommendation 1: Data collection and reporting on sexual orientation and gender identity in relation to drug use and harms needs to be improved.

Rationale: Current routine data sources do not capture sufficient detail on subgroups (sexual orientation, gender identity including TGNB identities, not just biological sex) within LGBT+ populations [Roberts et al., 2026]. In addition to use of agreed definitions and standardised terminology to improve quality and consistency, data collection and reporting could be improved in the following ways:

1. National surveys (such as Crime Survey for England and Wales (CSEW)), treatment data (NDTMS) and mortality data sets (coroners'/procurator fiscal reports) should consistently collect data on sexual orientation and gender identity with clear guidance on how this information can be found and how it has been collated.
2. Sexual health services should routinely report sections on chemsex drugs and sexual orientation as required in Genito-Urinary Medicine Clinic Activity Dataset (GUMCAD) V3, the mandatory surveillance system for STIs which collects data from all publicly commissioned sexual health services in England and similar activity within the devolved nations.

Leads: Department for Health and Social Care (DHSC), Department of Health Northern Ireland, Public Health Wales, Public Health Scotland, CSEW through Office for National Statistics (ONS), NHS Digital, National Drug Treatment Monitoring System (NDTMS) through Office for Health Improvement and Disparities (OHID), UK Health Security Agency (UKHSA), coroners and procurator fiscal service, drug treatment service providers, local commissioners.

Expected outcome: Agencies reporting or monitoring official and other data related to drug related harms routinely support the recording and stratification of harms by sexual orientation, gender identity and sex assigned at birth. This will help understanding of prevalence and trends across all LGBT+ sub-groups and the effectiveness of interventions.

Recommendation 2: Service integration is required to address the physical and psychosocial harms related to substance use within LGBT+ communities, including sexualised drug use and chemsex.

Rationale: Many of the harms and psychosocial aspects of health associated with drug use in LGBT+ communities, including in the context of sexualised drug use, are inter-related. Individuals may present with intersecting needs relating to substance use, sexual health, mental health, safeguarding, housing, and wider psychosocial support. Integrated and coordinated care

models can improve continuity of care, facilitate timely referrals and ensure that individuals receive holistic support that addresses the full range of risks and needs associated with substance use and sexualised drug use.

DHSC, and the equivalents in the devolved nations, should support Integrated Care Boards (ICBs) in England, Area Integrated Partnership Boards (AIPBs) in Northern Ireland, Integration Joint Boards (IJBs) in Scotland and Area Planning Boards in Wales and local authorities to commission and coordinate open access, clinically competent and culturally appropriate services to address the inter-related harms and psychosocial aspects of health due to substance use within LGBT+ communities, including in the context of sexualised drug use and chemsex. These services must also have an inter-connected pathway to local sexual assault referral centres and specialist sexual harms organisations.

In areas of higher demand (urban areas), local needs assessments should be conducted to gather a detailed understanding of the population requiring support and the nature of their needs. Based on this assessment, the relevant bodies, with support from DHSC and the equivalents in the devolved nations, should ensure that substance use services are co-located and integrated with sexual health services, supported by joint commissioning and funding arrangements.

In areas of lower demand (rural areas), commissioners and providers should establish clear referral pathways between services. These should include agreed referral protocols, information-sharing arrangements and mechanisms for coordinated care planning.

Lead: Department for Health and Social Care (DHSC), Department of Health Northern Ireland, Public Health Wales, Public Health Scotland, commissioners of sexual health and substance misuse services, British Association for Sexual Health and HIV (BASHH), Office for Health Improvement and Disparities (OHID), the Local Government Association, the Association of Directors of Public Health.

Expected outcome: More consistent referral and care pathways across the UK with established referral protocols linking sexual health, mental health, and substance use. Production of shared care plans with named clinical leads. Increased engagement with treatment and support services through reduced fragmentation between substance use, sexual health and mental health provision.

Recommendation 3: Improved workforce education and training on LGBT+ related drug use, chemsex, and associated health needs.

Rationale: Evidence suggests that improved staff understanding of LGBT+ health needs can enhance disclosure, engagement and treatment outcomes. National guidance and workforce training on chemsex would support consistent, non-stigmatising and effective responses across health and social care services.

DHSC, and the equivalents in the devolved nations, should work with NHS organisations, commissioned service providers and community-led organisations to create national guidance on supporting and managing those who use drugs in LGBT+ communities, sexualised drug use and chemsex. Training resources should be developed for staff across all services involved in the prevention, treatment and support of those who engage in chemsex, as well as for postgraduate programmes and specialty training curricula. Workforce training should promote informed, coordinated and non-stigmatising responses, helping to deliver a higher quality and non-judgemental service. Involving community-led organisations will ensure development of relevant, accessible, and culturally competent materials and programmes which reflect the needs of the community.

This will require work to encourage the relevant professional bodies to include sexualised drug use and chemsex within their accredited training schemes, at qualifying and post-qualifying stages, including continuing professional development.

The workforce must also have a working understanding of sexual harms, particularly rape and sexual assault, and understand ‘reporting pathways’ that include criminal justice and non-police reporting that is victim-focused and adheres to the Victims’ Code [MoJ, 2005].

Lead: Department for Health and Social Care (DHSC), Department of Health Northern Ireland, Public Health Wales, Public Health Scotland, Department for Education (DfE), NHS England, NHS Scotland, NHS Wales, Health and Social Care Northern Ireland, UK Health Security Agency (UKHSA), Royal College of General Practitioners, Royal College of Nursing, the Royal College of Psychiatrists, the Royal College of Physicians, Medical Schools council, British Association for Sexual Health and HIV (BASHH), Health Education England, the Academy of Royal Colleges, postgraduate programmes.

Expected outcome: Production of a national framework setting out standards of care for LGBT+ individuals and those practising chemsex. This should improve drug treatment and related health services for LGBT+ individuals.

Annex A: List of abbreviations used

ACMD	Advisory Council on the Misuse of Drugs
APMS	Adult Psychiatric Morbidity Survey
ART	Antiretroviral Therapy
ASTRA	Antiretrovirals, Sexual Transmission Risk and Attitudes
BASHH	British Association for Sexual Health and HIV
BBV	Bloodborne Virus
CM	Crystal Methamphetamine
CSEW	Crime Survey for England and Wales
DfE	Department for Education
DHSC	Department for Health and Social Care
Doxy-PEP	Doxycycline Post-exposure Prophylaxis
EMIS	European MSM Survey
GBL	Gamma-butyrolactone
GBMSM	Gay, Bisexual, and other Men who have Sex with Men
GHB	Gamma Hydroxybutyric Acid
GHBRS	GHB Related Substances
GMSS	Gay Men's Sex Survey
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HMPPS	His Majesty's Prison and Probation Service
ICB	Integrated Care Boards
LAMIS	Latin America Men who have Sex with Men Internet Survey
LGB	Lesbian, Gay, Bisexual
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBT+	Lesbian, Gay, Bisexual, Transgender plus
MDMA	3,4-Methylenedioxymethamphetamine
MPS	Metropolitan Police Service
Natsal	National Survey of Sexual Attitudes and Lifestyles
NDTMS	National Drug Treatment Monitoring System
NEPTUNE	Novel Psychoactive Treatment UK Network
NI	Northern Ireland
NPS	Novel Psychoactive Substances
NPSUM	National Programme on Substance Use Mortality
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PrEP	Pre-exposure Prophylaxis
SAMHSA	Substance Abuse and Mental Health Services Administration
STI	Sexually Transmitted Infection
TGNB	Transgender and Non-binary
UKDPC	UK Drug Policy Commission
UKHSA	United Kingdom Health Security Agency
WSW	Women who have Sex with Women

Annex B: Methodology

This report draws on evidence from UK and international peer-reviewed literature and government reports. The evidence gathered was considered in accordance with the ACMD's standard operating procedure for quality of evidence [ACMD, 2025b].

The ACMD issued a public call for evidence between 8th December 2025 and 30th January 2026, to gather qualitative insights from as broad a spectrum of participants as possible, to assist in formulating advice to government. This included responses from treatment providers, community organisations, and individuals with lived experience. Responses informed the analysis of barriers to treatment and suggested actions to improve treatment accessibility and engagement among LGBT+ communities.

Respondents were asked about their experience and knowledge of available services specifically for LGBT+ individuals experiencing harms related to drug use, including chemsex, and the barriers observed which prevent individuals from accessing support or treatment.

Respondents were also asked about effective interventions or harm reduction strategies specifically tailored to LGBT+ communities or in a chemsex context and which approaches or interventions are most helpful in reducing harms.

56 responses were provided by a range of relevant stakeholders across the UK including organisations and those with lived/living experience.

Boxes 1 and 2 summarise the written responses.

Box 1. Main barriers to treatment for LGBT+ communities

Stigma, mistrust and lack of culturally competent services

- Experiences of discrimination, fear of being misunderstood, and heteronormative assumptions can discourage LGBT+ individuals from seeking support and treatment.
- TGNB individuals frequently encounter misgendering, exclusion, or a lack of understanding within services.
- Many service providers lack training in LGBT+ health, chemsex, and related practices. As a result, responses may prioritise abstinence-focused approaches, overlook issues of consent and trauma, or fail to recognise the roles of pleasure, intimacy, and community. This can leave service users feeling misunderstood and unsupported.
- Concerns about being judged for sexual practices can act as a significant barrier to accessing care.
- Visible indicators of inclusion, such as posters, badges, inclusive language, and pronoun awareness, are often absent from statutory drug and alcohol services, reducing confidence that LGBT+ people will be treated with respect and understanding.

Treatment and service provision

- Concerns about confidentiality and the potential risk of being ‘outed’ can deter individuals from accessing support.
- Busy waiting rooms and fears of being recognised by others may create additional barriers to engagement.
- Access to specialist provision varies considerably by location, with many services concentrated in London and limited availability elsewhere.
- A lack of LGBT+ peers within treatment programmes can contribute to feelings of isolation and reduce opportunities for peer-support.
- Where specialist services are available, they are often designed primarily around the needs of people engaging in chemsex and GBMSM. This can leave other groups, such as LGBT+ women, feeling that their experiences and needs are not adequately reflected in service design or delivery.

Knowledge and awareness

- Some addiction services are reluctant or insufficiently equipped to address the sexual elements of chemsex. This can leave individuals feeling isolated and unsupported, with a sense that no single service fully understands their needs.
- Limited awareness of sexuality-specific patterns of substance use may result in support that is not appropriately tailored.
- Many services continue to focus primarily on opiates and alcohol, with less expertise in stimulant use and substances such as GHB/GBL.
- Abstinence-only approaches may not align with the lived experiences, goals, and realities of many LGBT+ people who use drugs, potentially reducing engagement with treatment and support services.

Box 2. Main ways to improve treatment accessibility and engagement among LGBT+ communities.

Data

- Strengthen data collection and reporting on substance use among LGBT+ communities by capturing sexual orientation, gender identity, and non-binary and gender-diverse identities, rather than relying solely on biological sex.
- Remove barriers that restrict changes to recorded gender to improve the accuracy and inclusivity of service data.

Education and Training

- Improve LGBT+ cultural competence and understanding of chemsex and sexualised drug use among healthcare professionals, social care practitioners, and police.
- Ensure service providers are equipped to deliver consistent, evidence-informed, and non-judgemental support, with clear pathways for timely and appropriate referrals.
- Increase public awareness and understanding of chemsex and sexualised drug use to reduce stigma and encourage earlier engagement with support services.

Service Provision

- Co-locate sexual health, mental health, and drug and alcohol services to strengthen referral pathways, reduce service fragmentation, and improve continuity of care.
- Increase the focus on psychological wellbeing within sexual health settings, including proactive assessment and referral to mental health support where appropriate.
- Deliver services that are explicitly LGBT+-affirmative, inclusive, and responsive to the diverse needs of LGBT+ communities.
- Adopt harm reduction approaches that recognise a range of treatment goals, rather than relying solely on abstinence-based models.

Peer Support Interventions

- Peer support is highly valued within LGBT+ communities, with group-based peer interventions often reported as particularly impactful in reducing isolation and promoting recovery and wellbeing.
- Co-producing education, prevention, and harm reduction resources with LGBT+ communities helps ensure that materials are accessible, culturally relevant, grounded in lived experience, and communicated using familiar and appropriate language.

Annex C: Drug use in LGBT+ communities working group membership

Working group Chair and co-chairs	
Professor David Wood	Professor of Clinical Toxicology and Consultant Physician, Guy's and St Thomas' NHS Foundation Trust, King's Health Partners and King's College London.
Dr Ann Sullivan*	Previous ACMD member (February 2018 to December 2024) and honorary working group co-chair. Honorary Consultant in HIV Medicine at Chelsea and Westminster.
Dr Joe Heskin*	Non-ACMD member honorary working group co-chair. Consultant in Genitourinary and HIV Medicine, Chelsea and Westminster NHS Foundation Trust.
Members of Working Group	
Professor Amira Guirguis	Chief Scientist of the Royal College of Pharmacy (RCPharm), Professor of Pharmacy and MPharm Programme Director at Swansea University.
Dr Michael Brady*	Sexual Health and HIV Consultant at King's College Hospital. National Advisor for LGBT Health NHS England.
Helen Byrne*	Director of Neighbourhood Health Rethink.
Dr Dean Connolly*	Specialty Registrar and NIHR Academic Clinical Fellow in Public Health, London School of Hygiene and Tropical Medicine.
Duncan Craig OBE*	Chief Executive Officer of We Are Survivors.
Dr Sara Croxford*	Public Health Registrar at UKHSA.
Robbie Currie*	Chief Executive of the National AIDS Trust.
Dr Jonathan Dewhurst*	Clinical Director at Greater Manchester Mental Health NHS Foundation Trust (GMMH).
Professor Saye Khoo*	Professor of Clinical Pharmacology and HIV Physician at University of Liverpool.
Darren Knight*	Chief Executive, George House Trust.
Monty Moncrieff MBE*	Chief Executive of London Friend.
Professor Fabrizio Schifano*	Professor of Clinical Pharmacology and Therapeutics at University of Hertfordshire, Consultant Psychiatrist in Addiction.
Dr Emmert Roberts*	Senior Clinical Lecturer in Addiction Psychiatry at the National Addiction Centre, Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and a Consultant Addiction Psychiatrist at the South London and the Maudsley (SLaM) NHS Foundation Trust.
Jack Wilkinson*	Manager of LGBT-specific service at Bristol Drugs Project.

* denotes co-opted member of the ACMD working group

Annex D: ACMD full council membership

Chair of ACMD Council	
Professor David Wood	Professor of Clinical Toxicology and Consultant Physician, Guy's and St Thomas' NHS Foundation Trust, King's Health Partners and King's College London
ACMD Council Members	
Professor Judith Aldridge	Professor of Criminology at University of Manchester
Professor Steve Allsop	Emeritus Professor, National Drug Research Institute, Curtin University, Australia
Professor Anne Campbell	Professor of Substance Use and Mental Health, and Co-Director of the Drug and Alcohol Research Network at Queen's University, Belfast
Dr Caroline Copeland	Senior Lecturer in Pharmacology and Toxicology, King's College London and Director, National Programme on Substance Use Mortality
Professor Colin Davidson	Professor of Neuropharmacology, University of Central Lancashire
Professor Karen Ersche	Professor of Addiction Neuroscience, University of Cambridge
Mr Mohammed Fessal	Chief Pharmacist, Change Grow Live
Professor Amira Guirguis	Chief Scientist of the Royal College of Pharmacy (RCPharm), Professor of Pharmacy and MPharm Programme Director at Swansea University
Dr Hilary Hamnett	Associate Professor in Forensic Science, University of Lincoln
Mr Jason Harwin	Director and Co-founder of E-T-E Solutions Limited
Professor Graeme Henderson	Honorary Professor of Pharmacology, School of Physiology, Pharmacology and Neuroscience, University of Bristol
Professor Katy Holloway	Professor of Criminology, University of South Wales
Professor Keith Humphreys	Esther Ting Memorial Professor of Psychiatry, Stanford University, USA
Professor Stephen Husbands	Professor of Medicinal Chemistry, University of Bath
Professor Sunjeev Kamboj	Professor of Translational Clinical Psychology Research Department of Clinical, Educational and Health Psychology, University College London
Professor Roger Knaggs	Professor in Pain Management and Clinical Pharmacy Practice, University of Nottingham
Mrs Sapna Lewis	Senior Lawyer, Welsh Government Legal Services Department

Dr Lorna Nisbet	Senior Lecturer and Principal Investigator for Forensic Toxicology at the Leverhulme Research Centre for Forensic Science, University of Dundee
Detective Sergeant Jon Privett	Detective Sergeant, Metropolitan Police Service
Mrs Fiona Spargo-Mabbs OBE	Director and Founder, Daniel Spargo-Mabbs Foundation. Chair, Drug Education Forum
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University
Professor Simon Thomas	Emeritus Professor of Clinical Pharmacology and Therapeutics, Newcastle University

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