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**Examining the drug, alcohol, and
chemsex experiences of LGBTQ+
people and the healthcare staff
supporting them**



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Background

Data from the Crime Survey for England and Wales, published by the Office for National Statistics, show that drug use in lesbian, gay, bisexual and trans (LGBTQ+) communities is significantly higher than for heterosexual and cisgender people. The use of 'chems' to enhance and prolong sexual activity is particularly associated with gay, bisexual and other men who have sex with men (GBMSM), with a very marked increase in the use of methamphetamine and GHB/GBL over recent years.

Other data consistently indicates that LGBTQ+ populations experience significant barriers when accessing healthcare services with many feeling the service provider and individual healthcare staff may not understand the substance they are using; the context in which they are used; or their broader experiences and needs as an LGBTQ+ person.

Services have seen an increase in the use of chems, with frequent disclosures made during consultations within sexual health services, however the prevalence of the issue is unknown. In 2025 the London Borough of Hammersmith & Fulham commissioned London Friend to carry out work to inform a local needs assessment. London Friend is the UK's oldest LGBTQ+ charity, providing support since 1972. London Friend runs Antidote, the LGBTQ+ drug and alcohol service, which has experience providing support and treatment since 2002, initially as part of Turning Point and since 2011 at London Friend. The activities delivered as part of the work are described on page 6.

A local report was presented to the commissioning authority; this public report collates some of the main findings from two focus groups and a professionals survey carried out locally in the commissioning Local Authority which may be applicable for service development in other areas. This report should be read in conjunction with the survey report published by London Friend and LGBT HERO which can be found here: www.londonfriend.org.uk/chemsexreport2026

Acknowledgements

London Friend would like to thank the LGBTQ+ people who responded to our survey; the local healthcare professionals within sexual health and drug treatment services who responded to our questionnaire; LGBT HERO who ran our survey; and the Antidote service users and local healthcare professionals who attended our focus groups for this project.

This report was written by Monty Moncrieff, London Friend's Chief Executive.



KEY FINDINGS & EXECUTIVE SUMMARY

A high number of LGBTQ+ people who have a drug or alcohol support express concerns about the impact of their drug use, particularly on their mental health, yet many have not accessed any support. Feelings of shame or embarrassment can further exacerbate the barriers we know LGBTQ+ people can experience when attempting to access mainstream healthcare services.

People we spoke to expressed a need to have access to a wide range of intervention types including harm reduction, out of hours support, and more holistic opportunities to address their substance use issues. They were especially clear about their desire for support to be LGBTQ+ specific and for the delivery of this to be by their LGBTQ+ peers, including those with lived experience of substance use issues.

A wide range of complex issues relating to chemsex and other substance use are being seen by healthcare professionals. These were more likely to be observed in sexual health settings than drug treatment settings. Those working in sexual health settings reported a greater frequency of presentations by clients with complex needs than are typically seen by staff in drug treatment services. This tallies with existing evidence that indicates LGBTQ+ people are more reluctant to access drug treatment services, which they often do not see as able to meet their needs.

Sexual health professionals also told us about the challenges they face with a lack of capacity to support clients within their services, and in making successful referrals to services that can support more complex drug and alcohol needs.

There is an urgent need to consider how and where such needs can be met, and to take the opportunity to support clients in the services they are already accessing rather than continuing with the expectation to go elsewhere.

Professionals working to support LGBTQ+ clients around substance use and chemsex indicated varying levels of knowledge and confidence and highlighted several outstanding training needs. Staff working in drug treatment services were less likely to have had any training around chemsex than those in sexual health services.

Concerns around the knowledge and competence of treatment services around LGBTQ+ people and emerging drugs were highlighted in the UK Drug Policy Commission's 2010 review of literature relating to LGBTQ+ drug use. Whilst some services have undoubtedly gained more experience and understanding since then, it is concerning that this is still perceived as a barrier some 15 years later.

Recommendations

Increase support provision and treatment delivered by and for LGBTQ+ people

The survey and service user focus groups indicated a very clear desire for support to be available targeted specifically at LGBTQ+ people, including by peers with lived experience. Our engagement found one-to-one and counselling interventions were particularly helpful, but participants indicated a need for a broad range of intervention types.

Co-locate more support in sexual health services

Sexual health services are felt to be more accessible than drug treatment services, particularly for many GBMSM. There is clear evidence of chemsex presentations at sexual health services, but it can be difficult to meet this need due to capacity and complexity. Current drug treatment in-reach into sexual health settings is welcomed and valued by staff but there is further opportunity to expand capacity including increasing speciality LGBTQ+ support that can be provided in the clinic where clients are and more proactively help to assist them to access other services.

In expanding support in sexual health settings consideration should also be given to the needs of other diverse LGBTQ+ populations. Lesbian and bisexual women may be less likely to access sexual health services in the same way as GBMSM. Similarly, GBMSM from minority ethnic backgrounds may experience different barriers accessing sexual health. Trans and non-binary people may be more comfortable access specialist sexual health clinics (such as cliniQ and 56T in London).

Increase access to harm reduction information

Service users told us how they did not always have sufficient knowledge about the substances they were using and the risks before they became problematic for them. Harm reduction resources and programmes specifically targeting LGBTQ+ people are available from organisations such as The Love Tank and GMHC (see Appendix D).

Develop LGBTQ+ peer support

Support delivered by LGBTQ+ peers with lived experience was the most important factor identified in our survey, with 85% saying they would find this helpful. There is opportunity to build on existing peer support initiatives that exist in HIV services and through volunteering programmes in LGBTQ+ services.

Increase training and professional development opportunities

Our survey of healthcare professionals identified opportunities to improve knowledge and confidence around chemsex. There is opportunity and appetite to develop professional development opportunities across services in local authorities and regionally.

Improved alignment with mental health support

Our engagement identified a significant need and high level of concern about mental health, but both service users and healthcare professionals have long reported difficulties to move between services, especially where drug use was still current. Club Drug Clinic, a service specialising in support for club drugs and other novel psychoactive substances rather than the traditional opiate and crack cocaine focus in most drug treatment services, identified a much greater involvement of mental health interventions in clients' care than are typically provided by drug treatment services. Anecdotal evidence suggests an increase in clients experiencing psychosis, particularly related to methamphetamine, indicating a growing need. There is opportunity for development of new models of care building on the expertise of services, including community-based support alongside clinical services.

Improved multi-agency care coordination

There was strong support from healthcare professionals to improve joint working to increase learning and improve client care coordination. Some Local Authorities have piloted multi-agency and multi-disciplinary mechanisms and there is opportunity for others to coordinate this across their services.



ACTIVITIES

Work for this needs assessment included:

- Survey of LGBTQ+ people with a substance support need
- Survey of healthcare professionals working in sexual health and drug treatment services in Hammersmith & Fulham.
- Focus group with healthcare professionals working in sexual health and drug treatment services in Hammersmith & Fulham.
- Focus group with service users accessing Antidote.

Survey of LGBTQ+ people with a substance support need

This survey received 334 responses. The results of this have been jointly published separately by London Friend and LGBT HERO here: www.londonfriend.org.uk/chemsexreport2026

Professionals survey - A survey of healthcare professionals working in sexual health and drug treatment services in Hammersmith & Fulham was circulated during November 2025 with 40 respondents. This was circulated to staff in the following services:

- 10 Hammersmith Broadway
- Turning Point
- Club Drug Clinic
- SASH
- John Hunter Clinic

Service user focus group - A focus group with service users accessing Antidote was held in November 2025 with 6 service users participating.

Professionals focus group - A focus group was held with healthcare professionals working in sexual health and drug treatment services in Hammersmith & Fulham in November 2025 with representation from the same services that circulated the professionals' survey.

SERVICE USER FOCUS GROUP

A focus group with service users accessing Antidote was held in November 2025 with 6 service users participating. The questions used to guide the discussion are at Appendix B. This summary analyses the discussion based on different themes.

The value of LGBTQ+ specific support.

The desire for LGBTQ+ specific support was strongly seen in the survey and the service user focus group. 78% of respondents to the survey indicated this was important to them with only 3% of respondents saying this was not important. In the focus groups participants described how they felt more comfortable within such services and felt the people they spoke to understood their needs better.

"I worked with other drug and alcohol services before finding Antidote. I didn't feel like some of the people I spoke to fully understood what I was talking about and some of the issues that I was facing and having a specifically LGBT service they had a better understanding. For me, it was very important, and I was quite happy that there was a service out there like that for me."

"It was somebody in sexual health at [name of clinic] that gave me the details for London Friend, and from the moment I contacted them and then attended the first Antidote drop-in, it just felt like I could open up a lot more, and there'd be no judgment. They understood where I was coming from with different things about my relationship with my family, my relationship to alcohol, they just seem to understand it so much more. They kind of understood about the impact it was having on family and the problems I'd had growing up, and stuff like that, so... they just... they just get you. They just understand you a lot better."

One participant succinctly summed up why this helped them to trust the service:

"X took me to Antidote, and I had an assessment, and I felt accepted straight away there."

We know that drug use and chemsex can be associated with stigma and feelings of shame and embarrassment, and that this can make it difficult for people to fully address the issues they are experiencing. One participant described how accessing LGBTQ+ support helped them to be open about their circumstances, and how they may not have felt able to be open in non-specific support services:

"If I'd gone to any other treatment service, I would have felt like there would have been a part of me that I would have had to have hidden, and I didn't feel like I had to hide, because I was around LGBT addicts." Being around other LGBTQ+ people with lived experience tallied with the view of those competing the survey where being able to access support from LGBTQ+ peers was highlighted as the most important consideration. 85% of respondents to the survey indicated this would be helpful.

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Some participants discussed how they felt they needed to explain aspects of being LGBTQ+ when working with non-LGBTQ+ healthcare professionals, which they didn't need to do within an LGBTQ+ service:

"My therapy isn't with someone that's LGBT, and you do find that you have to explain things and almost teach them about, like, the queer scene. [With an LGBTQ+ service] they already know that stuff, so you don't have to sit there and explain certain things, because they already know that, and that's the kind of people they're treating, so I do think it's very helpful, and you do feel a lot more comfortable in that setting."

For others it was more practical aspects of LGBTQ+ inclusive care:

"If you're attending that service, or you're going through a bit of a volatile time, you don't want to have to deal with things like explaining your pronouns and all of this."

The service's understanding of issues that were deemed important to LGBTQ+ people was also a significant factor in their choice of where to seek support; one participant related this back to their needs around their sexual health:

"It was very much a heteronormative service that they were offering. So things like PrEP and DoxyPEP, and all this, none of this was discussed, which is quite important within our community."

Experiences in mainstream services

Participants expressed uncertainty about 'mainstream' services' knowledge and experience in dealing with the drugs most prominently associated with chemsex:

"I think the skills that are required for recovery from G and T [GHB/GBL and 'Tina' or methamphetamine] and chemsex are completely different to the very traditional legacy drugs from the services."

"I've also found that particularly with my local authority support, I have had a lot of problems with G and T use, the knowledge in those areas is severely lacking."

Concerns were raised about the impact of feeling judged:

"It puts people off going in and getting help if they're sensing judgment. I'm lucky I'm not too much of an anxious person, but I've been in situations where if I was quite socially anxious, and you're sitting there, and you're feeling this judgment, and the way they're talking with you, it makes you not want to go and get that help."

One participant discussed an experience where lack of awareness of the drugs commonly associated with chemsex meant details were missed during an ambulance callout:

"I know one of my friends had an ambulance called for G use and the ambulance team looked from the side, and they just went, oh, that's cocaine. It wasn't cocaine, it was mephedrone, and they didn't even take in the G bottle."

Similarly, one participant discussed what could help to improve experiences in other NHS services such as emergency services.

"I think maybe more training for hospital staff, nurses, doctors, maybe more training for them in terms of dealing with addictions or people being admitted to A&E after overdoses, because I've been in that situation a couple of times, and just got major judgment from staff."

Harm reduction, education and outreach

We asked participants whether they felt they had enough information about risk at the time they were using. Their responses illustrated that many had started using drugs with little understanding of what they were using. This was often due to the fact they had been introduced to the substances by other people, particularly when use was in a sexual context.

"When I started, no, I didn't have any information, I didn't know what drugs I was really taking, I was just offered them, and then I just started using them, and then it just became a thing that I was doing, and I didn't really know the risks involved."

Awareness was lower with the drugs most closely associated with chemsex:

"I didn't know the drugs that I used. G I didn't even know existed. I'd heard of crystal meth because of, like, American TV shows, but I didn't know anything about it, basically. I didn't know what I was doing before I started."

The normalisation of substance use was a prominent theme, particular alcohol:

"No one even bats an eyelid if you say, oh, I'm going home and I'll have a glass of wine, which is actually 2 bottles."

"I think mine, with it being alcohol, is probably the socially acceptable one. It's kind of the one that's kind of normalized in society, if you like, and so the warnings that you see, they don't have any impact."



The close association with substance use and the LGBTQ+ bar and club scene enhanced this normalisation of substance use. Many people access these spaces when first exploring their identity as LGBTQ+ people seeking community and a way to meet other LGBTQ+ people. The higher density of LGBTQ+ people in larger cities like London, evidenced by data from the national Census, indicates many migrate to areas where they will find more LGBTQ+ services. Participants drew a clear link between such a move but highlighted that this can increase the risk of alcohol and drug use.

“Especially in gay life, a lot of it is centred around drinking and socialising and pubs and clubs, and if it’s not that, it’s Grindr. I know there are healthy options, there’s groups, and there’s meetups and stuff like that. I know there’s those things. But I think your automatic default when you move to London is to pubs and clubs. That’s one of the reasons you perhaps move here for that social scene, but it is still based quite a lot around alcohol.”

Although there was awareness of alternative options to meet others LGBTQ+ people such as social and activity groups it was still felt that the bar and club ‘scene’ offered most opportunity.

“It still feels like there’s pressure to take part in that kind of scene as well. Like, where do you go in the evening to meet your friends?”

Participants also talked about how this could make it harder to recognise they had an issue with their use.

“Everyone around me and, like, people at all of these events were all doing it, and it just seemed like that was just normal, and it’s fine to go to work after you’ve been partying or be up for this amount of time, because that’s what everyone that I felt on the queer scene that I was hanging out with was doing. You don’t realize that it’s getting to you.”

This was despite knowing that drug and alcohol use carried risk:

“I kind of knew, obviously, that, you know, drugs have an addiction possibility. You just kind of don’t realize you’re getting into it, and it’s starting to become a problem before you’re a lot deeper in it than you even realised.”



Participants felt there needed to be more information available, and some reflected the impact of large-scale public health campaigns like the information available on HIV/AIDS in previous decades:

“There needs to be a wholesale education drive. Like, there was for HIV and AIDS during the 90s, to young gay people like me at the time through gay youth groups.”

Outreach programmes like those previously funded by HIV prevention funding during that time were remembered for their impact; this was a time when HIV prevention funding was ringfenced in public health budgets.

“I remember, like, the Lads Project and stuff like that, they would actually go on to cruising areas and stuff like that, and really teach about HIV and AIDS, and other stuff, and so a lot of money was chucked to our community then for sexual health, and I think the same sort of thing needs to happen now.”

Person centred care

Participants valued support that was person centred and did not require abstinence, which may be perceived as a barrier.

“[One of the things] I liked about Antidote is that they also do, like, reduction. They’re a little bit more open to what you want. That was the thing that first got me involved, because I was like, okay, maybe I can explore my drug and alcohol use, because at the time, I didn’t necessarily want to quit some things.”

“It’s a much more inclusive way to offer services, to have that option, where it’s not just abstinence or using, you have the option to reduce use, and I think that that is definitely a better way to go.”

“I think, for me, the alcohol reduction rather than abstinence was one of the reasons it worked so well for me.”

Although many treatment services do not require abstinence there was a perception that they did, which can add a further barrier.

“One of the beautiful things about Antidote, at London Friend, is the multi-pronged approach that they take, in that you don’t have to have complete abstinence, whereas most drug services, they preach total abstinence.”

Awareness of such services is key; one participant described being told about the kind of support services that were available and feeling this choice was limited:

“Trying to access other services through your GP, what do you get? When I first reached out for help, I was offered 6 sessions of talking therapy. Well, that’s not - no offense to the person that did it, it was a student with a clipboard you know, and it just was pathetic, really. There was... there was no other options for me, and the GP was saying it’s either that or AA, they didn’t know anything else, he didn’t know any other services that I could access.”

Mental health

Respondents in the survey highlighted the close association with mental health and substance use. 73% of respondents highlighted this as a concern. This was the top concern in the survey. Among Antidote clients in 2024/25 half had a diagnosed mental health issue.

Participants in the focus groups expressed familiar concerns about the difficulties they can experience when trying to access mental health support whilst having an active substance use issue.

“You need to go and address your drug issue before they will continue for mental health whereas you actually need both.”

“You need treatment for both at the same time, as opposed to a precondition of getting the mental health treatment being that you address your drug use. Because you can’t address your drug use until you have some kind of intervention from the mental health team.”

One respondent described a challenge where being accepted by one type of service closed further access to another:



"I got discharged from Community Mental Health, and I can't get into the dual diagnosis [service] again because they discharged me when they put me through rehabs. It's like... yeah, it's all very disjointed."

Sexual health

Data from Antidote for 2024/25 indicates a close link with drug use and sexual health, with high engagement in sexual health services and health promotion interventions. There was a high level of testing for HIV, with only 3 of 441 clients reporting never having tested (testing history information was missing for a further 11 clients). The vast majority of those who had tested positive were engaged with treatment (91%); information was missing for 8.5% of clients and only 1 client who had received an HIV positive diagnosis was not engaged with treatment. HIV PrEP uptake among HIV negative clients was at 64%. This indicates a high level of engagement with sexual health services.

Focus group participants saw opportunities for drug and alcohol support to be more readily available via sexual health settings.

"Gay men, especially, will always visit sexual health clinics. We are quite good at that, we do look after our sexual health, and [it would be helpful] if there was more material in those types of places."

Participants indicated a willingness for their drug and alcohol use to be more closely explored in sexual health services.

"Perhaps if there was more discussion when you're talking about your sexual health that you touch on it about drugs and alcohol and stuff. If there was a little bit more probing and then signposting it could be quite good."

The experiences of healthcare professionals working in sexual health within the Borough similarly indicate a high level of engagement by GBMSM engaged in chemsex. However, our survey indicated a very high level of potential chemsex-related harm observed by sexual health professionals.

In focus groups sexual health professionals highlighted a difficulty in clients connecting with services that could support with these needs. There is opportunity to expand support within sexual health services, particularly to help link clients who are already engaging with those services but who may be reluctant to self-refer to others.

Although engagement in sexual health services is generally high among GBMSM this approach may be less effective for lesbian and bi women and for trans and non-binary people who may be less engaged with these services.

Although London has some trans-specific sexual health services, such as cliniQ and 56T, trans and non-binary people experience barriers when accessing appropriate sexual health advice and there are few, if any, dedicated services for lesbian and bi women who may be frustrated by an assumptive focus on reproductive health when they are not reporting sex with men.



What would be helpful?

Participants discussed some of the aspects of their support received from Antidote, valuing the open access nature of the service, and the fact they could use the weekly drop-in sessions as they needed them.

"You can access as soon as you need it and not be on, like, a waiting list."

"I know every single week I could go there and, like, doing something that was helping me, not just waiting."

However, it should be stressed that Antidote does have waiting lists for structured one-to-one support due to demand for the service, or clients may be waiting for a group programme to start its next cycle.

Data from the survey and discussion in the focus groups indicated that although LGBTQ+ specific support was important, there was no 'one-size-fits-all' approach that was universally praised. Some valued group programmes and hearing other people's perspectives; some appreciated that the Antidote drop-in offered the opportunity to speak to different staff and volunteers each time; but others felt more cautious about sharing in group settings and valued one-to-one work more.

"Attending the Antidote drop-ins, I used to go on a Thursday night in Soho and I remember when I first started going, I was thinking maybe I'm gonna struggle with the fact that I

was talking to a different person each week. But as time went on, I realised that that was actually a good thing for me, because I was getting different kind of viewpoints or different input from different people, and different types of people. And people would bring in different views to the table and bringing different things out of me as well. I was talking about different things with the different people. So, in the end, I viewed that as a huge positive, that I wasn't seeing the same person every week. There was a bit of variety there."

"I found one-on-one sessions helpful because it's private, I didn't have to share stuff in a group, which I wasn't ready to do."

"I probably would have been put off by going if it was a group setting, and I found [individual sessions] one of the things really helpful for me, especially, if you're coming in and you're in a bit of a fragile kind of way, you don't want to sit there in a group, necessarily, and it's all a bit scary, whereas knowing that you can just go into a room with one person, I found really helpful and really persuasive for me to go and to also keep going back, because there's times that you just want to just speak with one person and not have to worry about everything else."

Service provision at the weekend was welcomed, such as the Antidote Sunday Sessions. These are psychoeducational discussion-based workshops on a theme relevant to maintaining drug and alcohol treatment goals and to being LGBTQ+ people managing a drug or alcohol issue that are provided monthly.



“Sunday Sessions, I found that helpful, particularly that they’re on a certain theme.”

The Sunday Sessions also encourage the formation of supportive peer relationships and engaging in social and leisure activities with peers. Antidote additionally organises at least one social activity per month for clients, such as a gallery visit, theatre show, film screening, or outdoor activity. These were highly valued by focus group participants who liked the fact they were supportive but did not have a focus on only discussing drug and alcohol issues.

“The social, it’s just nice to do an activity and not have it be focused on drugs or alcohol or talking about health.”

They were also seen as a good way of overcoming anxiety about meeting other people in similar situations.

“Socials, based around an activity that takes away the awkwardness of people who are strangers coming together.”

Additional services such as complementary therapies were also valued.

“And acupuncture’s also really good, I’ve got to say, the acupuncture’s great.”

Participants were clear though that they did not want to be limited to accessing only Antidote and that other services needed to improve access.

“I think there should be a dedicated LGBT led and centred drug integrated service within every community drug team.”

“I don’t want to see Antidote disappear, but I think it’s the responsibility of the government to provide these services, and I think that needs to be done on a national level.”

Sometimes this was linked to the understanding that they would not be able to access some services without attending mainstream services.

“There’s only so much the charity sector can do, but if you do want to access a rehab or detox, you have to then go with your local drug service.”

12-step and similar programmes have long run meetings targeted at LGBTQ+ populations and these form a vital ongoing support function for many people who have chosen abstinence. These have evolved to meet emerging need, such as chemsex, with Crystal Meth Anonymous (CMA) meetings now offered alongside the more traditional Alcoholics Anonymous and Narcotics Anonymous meetings.

London Friend hosts a weekly independently run CMA meeting from our base in Kings Cross. Whilst such services are highly valued by those attending, concern was expressed about a perceived ‘over reliance’ on these and other charity sector services filling in perceived gaps and meeting need that statutory services were felt not to be meeting.

“I think there’s an over-reliance on the 12 steps program, and I think it’s a lazy way for cash-strapped services to, kind of, offload their responsibility, which seems to be going on more and more, and it seems to be more and more the charity sector that is picking things up where statutory services are dropping the ball.”

Frustrations with local residency requirements

The different eligibility criteria for sexual health (which is open access) and drug treatment (which is typically restricted to residents of the local authority commissioning the service) was something of a 'hot topic' in both the client and the healthcare professionals' focus groups.

Many LGBTQ+ clients, particularly GBMSM, enjoy the ability to choose those sexual health services that have an excellent reputation for being LGBTQ+ inclusive but lack this choice if they require referral on to drug treatment services where experience of working with LGBTQ+ people and chemsex can vary widely, particularly across London Boroughs.

"There's different levels of support in different boroughs and is not consistent."

The fact that people live, work, and socialise in London as one city whilst administratively it is organised as 33 separate Boroughs for many public services was particularly frustrating.

"I think there should be more consistency with services that are offered in different locations. I understand that different parts of the country might have different needs, but even within London, there is such disparity depending on where you live, what borough you're in, or what health authority, what is available to you. If I were to live 5 minutes' walk down the road in a different borough, I've got completely different services available to me even though it's the same city."

Participants also expressed annoyance that having to move house could affect what support was then available to them.

"I've had a situation before where I've been on a list for something, but then I've moved somewhere else, and then it comes under a different health authority, so I've got to start again. If it's the same city, why can't it just be that it doesn't matter where you live."

Similar frustrations were expressed in the healthcare professionals' focus group, particularly in relation to making onward referrals.





HEALTHCARE PROFESSIONALS' SURVEY

Respondents

40 healthcare professionals responded to the survey. The breakdown across services was:

- Sexual health = 15
- Drug treatment = 19
- Both = 6

Experience of providing chemsex support

Staff in sexual health services were more likely to have supported clients around chemsex than those in drug treatment services, with **87%** reporting experience in sexual health and **42%** in drug treatment. Two thirds (**66%**) of staff whose role encompassed both had experience of supporting clients around chemsex.

The extent of this experience was mixed: in sexual health **20%** reported supporting 'a lot' of clients with **67%** supporting 'a few'. In drug treatment **21%** had supported 'a lot' and **21%** 'a few'.

Only 1 respondent from a sexual health setting (**7%**) reported not having worked with clients around chemsex, and a further 1 was unsure. This contrasted with drug treatment where staff were far more likely to not have supported chemsex clients (**53%**) with 1 (**5%**) unsure. One third (**33%**) whose role encompassed both had not supported any clients around chemsex.

This suggests that clients are more likely to seek support from a sexual health setting than drug treatment, which supports existing evidence.

Training

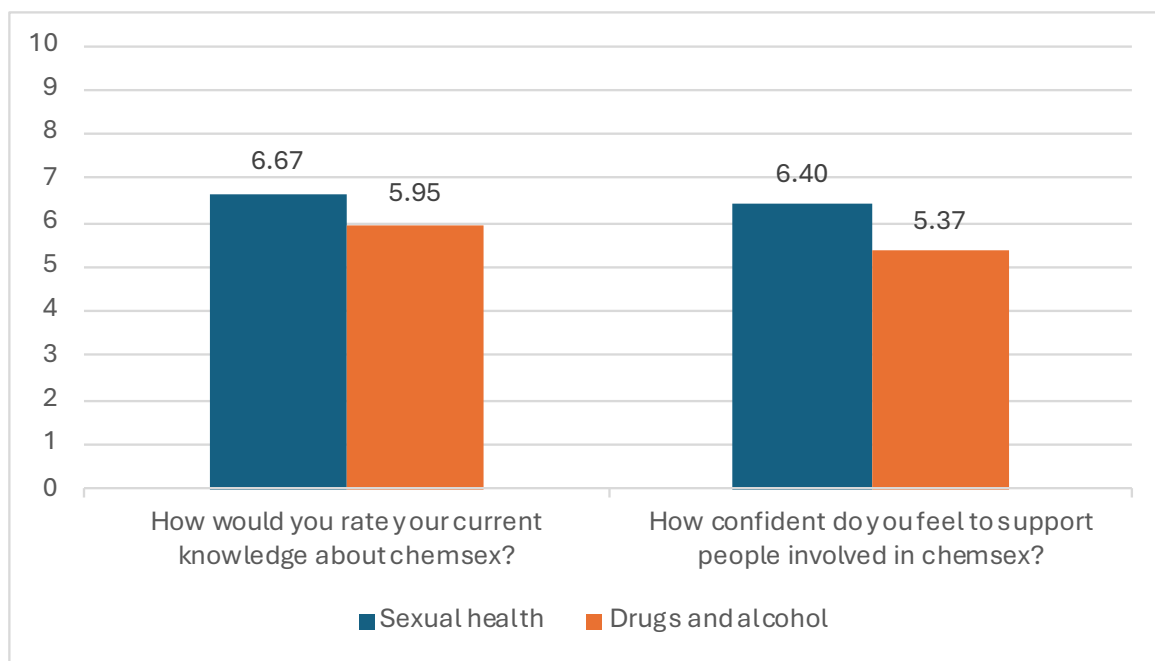
Staff in sexual health services were more likely to have received training on chemsex with **80%** reporting previous training and **20%** reporting none. For staff working in drug treatment services this was more evenly split, with **53%** reporting having received training and **47%** not. Staff whose role encompassed both were split 50/50.

Training had not been delivered in any standard way, with respondents reporting having received this in a variety of ways and from a variety of sources. These included from drug treatment and sexual health organisations and third sector providers including London Friend, THT, 56 Dean Street, SASH and Galop. Some of this was provided in person, some online, and some was via e-learning. A handful of respondents reported having learned from other colleagues' experiences.

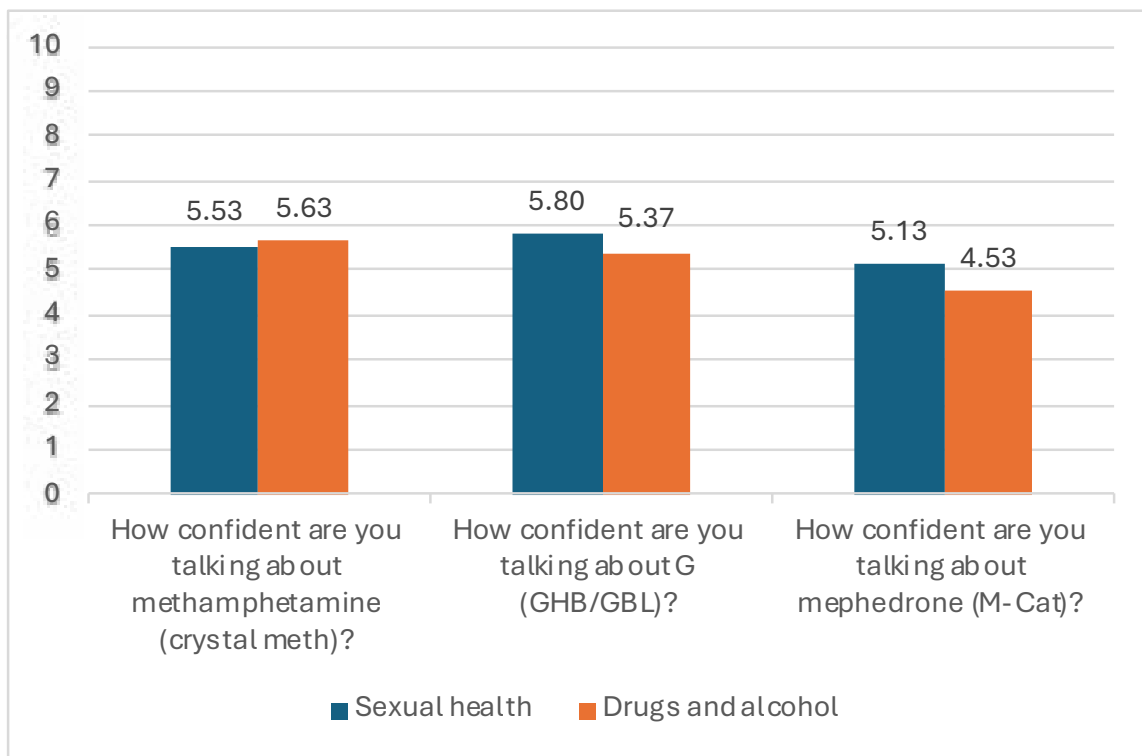
Knowledge and confidence around chems and sexual health

We asked respondents to indicate their knowledge of chemsex generally, then additionally their confidence around discussing both chemsex generally and individual substances commonly associated with chemsex (methamphetamine; GHB/GBL; and mephedrone); around aspects of sexual health, including HIV PrEP; other HIV prevention initiative; and around more recent developments in sexual health promotion such as Doxy PEP and Mpox vaccinations.

Knowledge of chemsex varied, although respondents rated both this, and their confidence in supporting people around chemsex in mid-range scores, under 7 out of 10 for sexual health staff and under 6 out of 10 for drug treatment staff on average. Individual responses varied very significantly from 2/10 to 10/10. Both knowledge and confident were marginally higher on average in staff in sexual health settings.

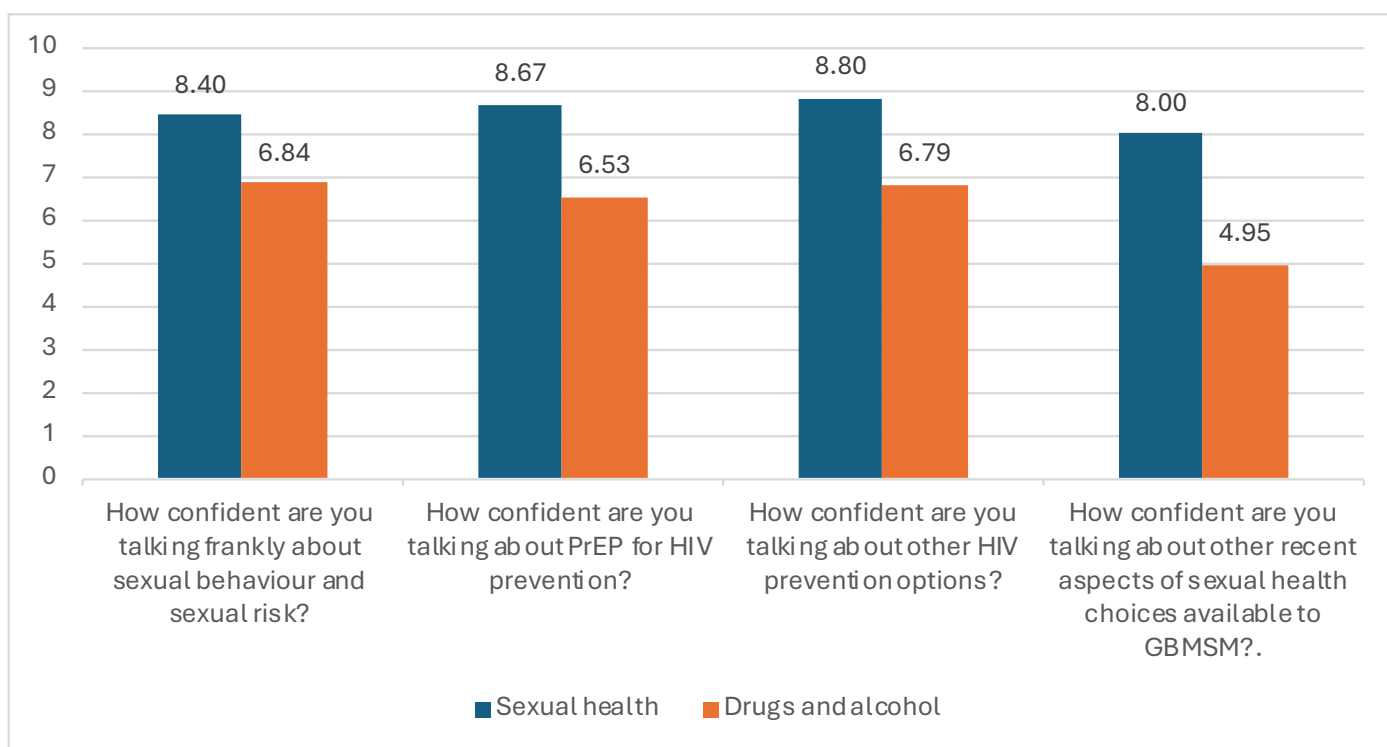


Confidence around discussing the individual substances was ranked mid-range on average by healthcare professionals, at similar levels for methamphetamine and GHB/GBL, and a little lower for mephedrone, perhaps reflecting that this substance is now less commonly reported by clients. A comparison between service type is provided below, but this was broadly similar across sexual health and drug treatment services. Individual responses again varied very significantly with respondents selecting every response level from 1/10 to 10/10.



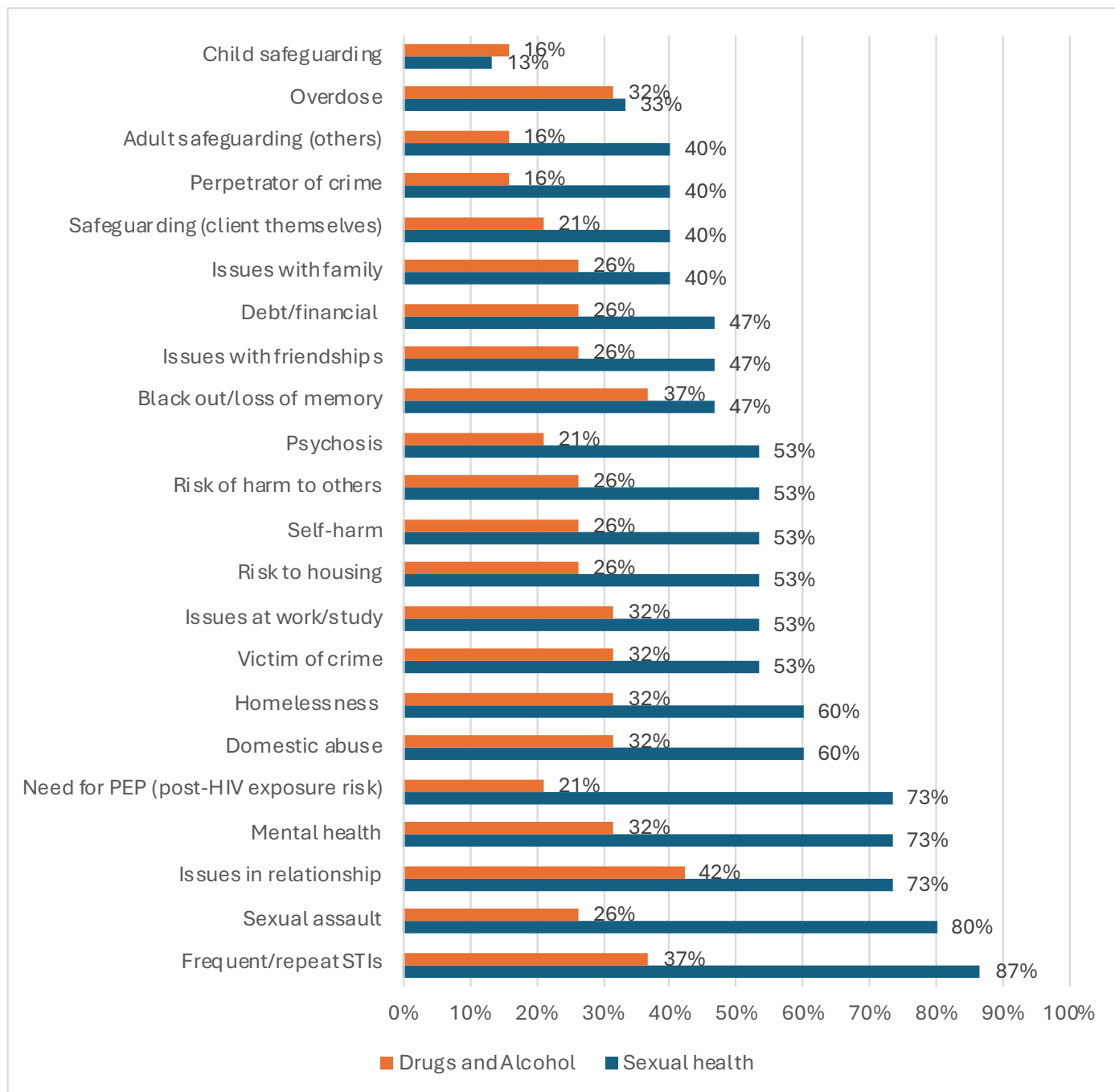
Confidence was higher for discussing sexual health and risk; PrEP for HIV prevention; and other HIV prevention options. It was a little lower for more recent aspects of HIV prevention and sexual health promotion. Individual responses again varied significantly from 1/10 to 10/10 for all questions except for general sexual health and risk where responses started at 3/10.

There was a more distinct difference between respondents from sexual health and drug treatment services with higher levels of confidence reported by sexual health professionals, particularly for the more recent aspects of sexual health promotion, as indicated below.



Complex needs

We asked respondents whether they had encountered a range of additional needs when supporting clients around chemsex. A significant number reported encountering many of these, particularly those working in sexual health.



The responses illustrate how clients are presenting to sexual health services with needs well beyond the scope of these services. This corresponds with the experiences shared in the professionals working group where staff working in sexual health clinics discussed how difficult it can be for clients to transfer to different services for support, and how the limited capacity in sexual health clinics made it difficult to fully address these needs while clients were onsite. There is opportunity to build on clients' attendance in sexual health clients to offer a wider range of support for their drug, alcohol, and other complex needs in a setting they are already attending.



Knowledge and confidence about additional support

We asked respondents about their knowledge of other services offering specialist chemsex information and/or support, and how confident they felt in knowing where to refer clients to for additional support. Respondents were fairly confident about knowing where to refer clients (7.22/10 on average) with all but 2 individual responses indicating 5/10 or higher. This was broadly similar across a range of professional backgrounds averaging 7.7/10 among sexual health staff; 6.8 among drug treatment staff; and 7.5/10 for staff working across both specialisms.

Concerns

We asked respondents if, based on their experience of providing support, they had concerns around chemsex, both for service users and for themselves as healthcare professionals. Respondents were able to respond with free text. There was a broad range of responses, but some key themes emerged.

For clients concerns included:

- Risk of overdose
- Risk of exploitation
- Risk to mental health
- Risk of sexual assault
- Sexual health risks
- Difficulty to recognise where drug use was causing problems
- Risk to employment and housing security
- Underlying issues e.g. loneliness, isolation
- Ability to enjoy sex without substances
- Access to culturally appropriate services

For professionals themselves concerns included:

- Safety
- Impact of stigma
- Trauma
- Complex needs
- Lack of professional experience to provide support
- Adherence to HIV treatment and other medication
- Capacity to meet full range of support needs
- Concern over missing other population groups at risk



Further training needs

We asked respondents to indicate where they felt they needed more training to support clients around chemsex. The greatest need, indicated across staff in both sexual health and drug treatment, was training to help identify and assess chemsex needs. This was indicated by 60% of staff in sexual health; 68% in drug treatment; and 50% for those working in both.

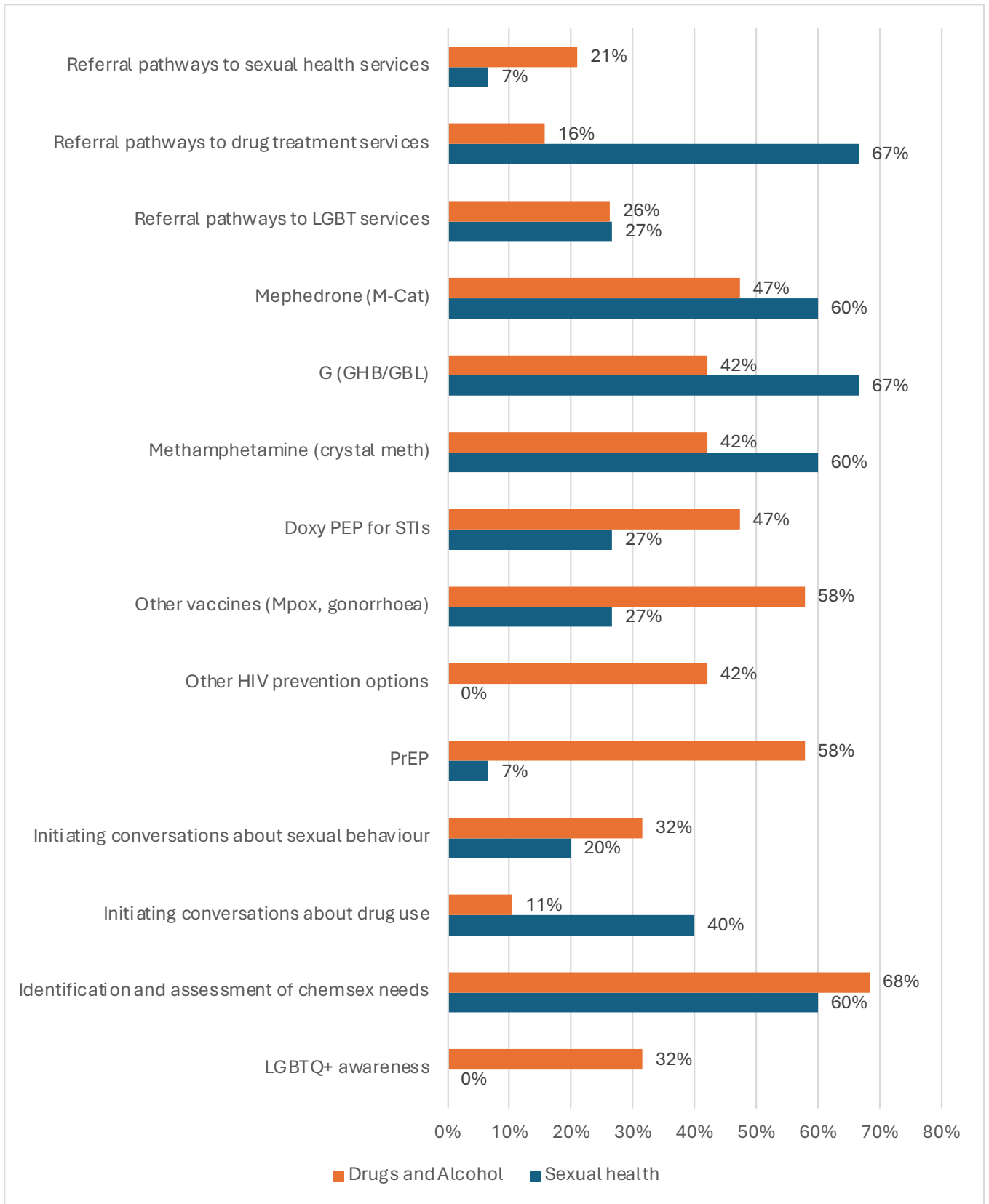
Unsurprisingly staff in sexual health settings indicated a greater need for training in the individual substances associated with chemsex than those working in drug treatment, and vice versa for training around sexual health and HIV for staff in drug treatment services.

A significant number of drug treatment staff expressed a desire for additional training on the chemsex drugs: 42% wanted more training on methamphetamine and GHB/GBL, with 47% wanting training on mephedrone.

Although sexual health staff did not indicate any significant training need around general sexual health and HIV prevention, just over a quarter (27%) would welcome more training on newer sexual health interventions such as Doxy PEP and vaccinations for gonorrhoea and Mpox.

Two thirds (67%) of sexual health staff indicated a training need around referral pathways to drug treatment services, with one-fifth (21%) of drug treatment staff indicating a similar training need around referral pathways to sexual health. This supports existing evidence of higher engagement in sexual health support than drug treatment support by clients engaged in chemsex.

Just over one quarter of staff across settings indicated a training need around referral pathways to LGBTQ+ services. Staff in sexual health settings did not indicate a training need around general LGBTQ+ awareness, but one third (33%) of staff in drug treatment services did. This supports existing evidence of greater comfort in accessing sexual health services by LGBTQ+ people than in accessing drug treatment services.



HEALTHCARE PROFESSIONALS' FOCUS GROUP

A focus group with healthcare professionals working in drug treatment and sexual health services in the Borough was held in November 2025 with 5 services working in Hammersmith & Fulham represented. The questions used to guide the discussion are at Appendix C. This summary analyses the discussion based on different themes.

Existing support services and their experience

The local authority offers support within its main drug treatment service run by Turning Point with a subcontracted recovery worker employed by London Friend's Antidote team. This offers a specialist LGBTQ+ and chemsex treatment pathway within the service.

Additionally, the Borough commissions the Club Drug Clinic (CDC) which has significant experience and UK-leading expertise supporting clients around chemsex issues.

Clients additionally access support through sexual health clinics and HIV services at 10 Hammersmith Broadway (10HB) and the John Hunter Clinic. Community sexual health support, including coaching and counselling is available through SASH. CDC also currently provides satellite sessions at 10HB.

CDC offers comprehensive drug treatment for local residents. They described how this support often needs to include psychological support as well as what may be thought of more traditional drug treatment. They outlined how important it is for this to be grounded in psychosexual competency.

"We utilise in-house psychology at a rate around 10x that typically offered in mainstream drug services, and this incorporates a psychosexual element that runs throughout or work. All our staff have had some introduction

psychosexual training to understand the basic concepts and to map this to the psychological aspect of our general substance work."

Sexual health services spoke about the support available there. This was not typically specialist chemsex support but drew on existing skills and experience of staff in other roles and often required onward referral.

"We have health advisors we can refer patients to, but they have a relatively limited role, and they signpost onto the various services."

"[We have a] multidisciplinary team who work in clinic, both in our HIV and GUM services who do a lot of signposting to local services. We don't have formally trained staff to manage people in a consistent way. We have people with a lot of MI skills, behaviour change skills, people who might have psychology backgrounds or other kind of backgrounds where they're able to work with clients, but we don't have a formal setup."

Like the participants in the client focus group professionals expressed frustration about the local residency criteria of services.

"It's also very dependent on your area of residence as to what services they can access."

Participants shared that clients were often quite willing to discuss their drug use, but that it was important for professionals to initiate the conversation.

"There's not a lot of resistance from people. When you ask, people are very au fait with us asking those questions openly, and they're fairly standard questions we ask everybody."

"I think it's variable. I think if you ask the right questions and create the right space, you will get the right answers back."



However, sometimes there could be concerns about confidentiality, particularly where the client may have concerns related to the employment.

“Many patients are reluctant to talk about their drug use. We’ve had a number of individuals who have had positions of responsibility”

This creates a potential difficulty for professionals, needing to create a rapport and build trust with clients so that everything can be discussed with openness and honesty, and the need to balance safeguarding concerns where disclosed. Professionals identified frequent issues around shame and stigma when clients did discuss their use of drugs for sex. It was clear professionals felt that services would need to be able to help clients with this.

“Once you start talking about it, it’s about stigma, shame, social isolation, loneliness. And once you start kind of unpacking that, where do people go, what support are they getting? What else is going on in the rest of their life?”

“There are lots of things at the root of [their chemsex use], but it really feels like it’s stigma, shame, loneliness.”

“Stigma comes up a lot, I think, is this one of the things we’re very mindful of. I mean, we’re talking about a population and a set of behaviours about which there’s multiple stigma, you know, there’s stigma around being gay, there’s stigma around gay sex, there’s stigma around drug use, there’s a stigma around injecting drug use, stigma around sexualised drug use, stigma around living with HIV.”

The greatest concern expressed by sexual health professionals was whether clients were able to recognise how significant their issues were.

“We ask about recreational drug use and any issues they have with their drug consumption. I think the difficulty is often the patient recognising when there’s a problem.”

“I think many individuals are unaware that their drug use is out of control or a problem.”

“The biggest challenge that I’ve personally found for patients who are using substances there is no guidelines as to triggers of when they think they should self-refer, or thresholds that they cross where the misuse is becoming an issue. And it starts off at one weekend, then it’s at every other weekend, then it’s weekly, then it leeches into the week, and you explain this, and you see it so, so often. It’s the sad, slow decline of individuals when they start losing their job, they lose their income, then their friends, their family, their home.”

One participant described how the association with using drugs during sex can exacerbate the difficulty in recognising when use had become a problem.

"They don't recognise when it becomes a problem. I think because it's often, predominantly associated or entwined with sex, and that's very difficult for them to disentangle and split. They find they've required drugs for the purpose of sex."

Capacity challenges in sexual health settings
Whilst professionals were clear about the value of clients being able to access support in sexual health clinics, they raised concerns about the capacity of the service to meet the full range of presenting needs. This was due to both the limited time available during consultations but also due to the complexity of the needs professionals were seeing.

"It's having the time to talk to people about things. If you're a clinician in a 20-minute sexual health appointment, or a relatively short HIV appointment, it's having the time to do the things that you might feel need to be done or having the space to make an appointment for somebody to come back and see one of the health advisers."

"The time constraint that would be of greatest concern to people, knowing what to do with the conversation, how to have the conversation, know what to say."

"I think it's also difficult when you're in a sexual health consultation to get valuable information during that conversation, because you have a very brief relationship with them. It's about 15-20 minutes, some you've not seen before, and probably will never see again."





Linking to further support

A clear theme emerging from the focus group was how to better link clients to the further support they needed. Professionals highlighted the difficulty of just signposting to other support, and how this could be a difficult step for clients. "There is drug treatment, there is community sexual health support, there are other services that are there, but it does feel as though the identification of that need, and therefore the progression into those services is still a bit of a challenge."

Professionals expressed a desire for more opportunity to link people to support directly accessible from sexual health settings, building on the fact they had already accessed one service.

"We see a lot of repeat attenders. it would be nice to say, "Actually, we've got some people who hang out here a couple of three days a week who it might be useful for you to touch base with".

The in-reach provided by drug treatment services in sexual health services was welcomed, although again expressed frustration with local eligibility requirements. There was support for expanding the availability of support in sexual health clinics.

"Having CDC here has been a good thing, but they work in a very structured way and have to refer people elsewhere [where they don't live locally]. I've often thought it would be good to have better partnership work throughout, with organisations like yourselves, who were here and available for people coming in as walk-ins."

"We are pretty much open access. It's fairly easy for people to book an appointment with us to come in with a problem. Compared to trying to access services elsewhere a lot of the time, however that might be. So I think it's often, you know, easier for people, it is more accessible [at sexual health clinics]."

Complex needs

The healthcare professionals survey illustrated the wide range of complex issues seen in services, and how these were more frequently seen by sexual health professionals. This was a key issue in our focus group discussions.

"There is a subset of people for whom it's linked in with mental health issues, housing issues. HIV, lost follow-up, non-adherence issues, and then that's the stuff, you know, safeguarding issues - that's the stuff that you then find you certainly don't have the time in the middle of clinic to do, but you've got somebody there with you."

"And there's a small subsection of people who do present repeatedly, more often, with lots of ongoing associated issues. And they require kind of a lot more time and effort without necessarily getting to the root of what the issues are, because they're trying to get support in lots of areas of their lives, and often nothing is particularly joined up or working very well."

Participants discussed the challenge of meeting the complex needs they see presented in sexual health services and how clients could be helped to connect to other services more easily.

"It feels as though people are coming to this service, maybe because it's more accessible for them, or they're more comfortable coming there and there's a lot of other presenting need that's way beyond the scope or capacity of what these services are set up to do. That needs to be somehow met, or some additional support brought into those settings to try and meet that through other specialist services."

"I can see the frustration from a client's point of view of just being signposted to everywhere but not having one particular service or particular person that, like, they can speak to."

Mental health featured prominently in these discussions.

"When patients come in with mental health issues there's a lot of self-medicating that's going on, but that's not always, um, they're not always aware that that's what they're necessarily doing."

One participant discussed one of the acute challenges regarding people who present whilst still high from using stimulants.

"I think the challenge for me is for patients who are not an extreme case who probably aren't suitable for A&E. We see it quite frequently those who have used drugs who are high, who haven't slept for a few days, they need something to help them sleep, to calm them down. They're perhaps a little bit paranoid, but they don't want to stop, and the psychiatrist won't see them unless they want to actually give up drugs, they're not willing to do that."

The patient in front of you clearly needs help, but we have no resources to deal with them. They're not going to sit in A&E for 8 hours. They're not going to see a psychiatrist very quickly. What do you do with that person in front of you at the time? For those, I think there are very few services available for them."

Joint working

There was a clear appetite for improved joint working and bringing services together.

"How we could kind of use what's out there and work together better."

Participants were also thinking about the mechanisms by which this could be done.

"Conversations like today's are great, and I think it'd be really important if you could have any leverage on a local level, just getting people together in a regular forum or a network, raise awareness of services, improve pathways of kind of referral, look at things we can do."

This demonstrates a willingness in the Borough to work collaboratively. Formalising structures to provide regular opportunities to share knowledge and experience also present opportunities to consider developing multi-agency, multi-disciplinary meetings to improve client care.



Appendix A

Questions asked in the Professionals' survey

1. What is the main focus of your work?

- Drugs and alcohol
- Sexual health
- Both

2. If you answered other, please tell us more about the scope of your role.

3. How would you rate your current knowledge about chemsex?

Scale 1 – 10

4. How confident do you feel to support people involved in chemsex?

Scale 1 – 10

5. Have you supported any clients who are engaged in chemsex?

- Yes - a lot
- Yes - a few
- No
- Not sure

6. Have you had any training related to chemsex before?

- Yes
- No

7. If yes please tell us some more about this, e.g., who provided this, what topics were covered, duration and recency of training etc.

8. How confident are you talking about methamphetamine (crystal meth)?

Scale 1 – 10

9. How confident are you talking about G (GHB/GBL)?

Scale 1 – 10

10. How confident are you talking about mephedrone (M-Cat)?

Scale 1 – 10

11. How confident are you talking frankly about sexual behaviour and sexual risk?

Scale 1 – 10

12. How confident are you talking about PrEP for HIV prevention?

Scale 1 – 10

13. How confident are you talking about other HIV prevention options (condoms, regular testing, treatment as prevention (TasP), U=U (undetectable = untransmittable), PEP)?

Scale 1 – 10

14. How confident are you talking about other recent aspects of sexual health choices available to GBMSM? E.g., M-pox vaccinations; gonorrhoea vaccinations; Doxy PEP.

Scale 1 – 10

15. Where you have supported GBMSM around chemsex what range of issues have you encountered in the work? (Please tick all that apply)

- Frequent/repeat STIs
- Need for PEP (post-HIV exposure risk)
- Overdose
- Black out/loss of memory
- Sexual assault
- Mental health
- Psychosis
- Victim of crime
- Perpetrator of crime
- Issues at work/study
- Issues in relationship
- Issues with family
- Issues with friendships
- Domestic abuse
- Homelessness
- Risk to housing
- Debt/financial
- Self-harm
- Risk of harm to others
- Child safeguarding
- Adult safeguarding (others)
- Safeguarding (client themselves)

16. How confident are you that you know where to refer a client for further chemsex support?

Scale 1 – 10

17. Which of these services offering specialist chemsex support and/or information are you already aware of? (Please tick all that apply)

- Antidote
- Club Drug Clinic
- SASH
- Controlling Chemsex
- Gay Men's Health Collective (GMHC)
- The Love Tank

18. If you have worked with clients engaged in chemsex what would you say are your biggest concerns for them?

19. And what are your biggest concerns around chemsex as a healthcare professional?

20. What areas do you feel you need more training/support around (tick all that apply)?

- LGBTQ+ awareness
- Identification and assessment of chemsex needs
- Initiating conversations about drug use
- Initiating conversations about sexual behaviour
- PrEP
- Other HIV prevention options
- Other vaccines (Mpox, gonorrhoea)
- Doxy PEP for STIs
- Methamphetamine (crystal meth)
- G (GHB/GBL)
- Mephedrone (M-Cat)
- Referral pathways to LGBT services
- Referral pathways to drug treatment services
- Referral pathways to sexual health services

21. Please use this space if you would like to provide us with any further comments about working with LGBTQ+ people and those engaged in chemsex (optional).

Appendix B

Questions used to guide service user focus group

1. You have all sought support from a drug and alcohol service which works specifically with LGBTQ+ people. Was this important to you, and if so why?

a) What is your experience of accessing mainstream services? Did you feel your issues are understood?

b) If you haven't accessed mainstream services, why not? Why did you think Antidote would be a better service for you?

2. What has been helpful for you in terms of support? What has worked best? And what has been unhelpful or hasn't worked?

3. What do you feel are the biggest issues that need to be addressed for LGBTQ+ people who experience problems around drugs or alcohol?

a) Have these changed in recent years? If so, how?

4. When you were using did you feel you had adequate information about the risks associated with the drugs you were using?

a) If not, what would have helped?

b) What information would have helped you be better informed?

c) How should such information be available?

5. What kind of services would you like to be able to access?

a) Prompts: Think about the locations, times, access, etc., and also about the types of support that services can provide.

b) Prompts: drug treatment services, NHS, charities, GUM, hospitals, GP, elsewhere.

c) Prompts: one-to-one, groups, drop-in, complementary therapies, relapse prevention, online, apps, SMS, telephone, 12-step, 'check-in'/'touch-base' services, etc.

6. Have you had any negative reactions relating to the fact you're LGBTQ+ when you've accessed health services?

a) Did this put you off going back?

b) Would it put you off seeking support in the future?

7. The commissioning of drug services is done locally within local authorities, and most services are only open to people who live in that authority. Do you think this is the right approach?

a) Do you think this approach meets the needs of LGBTQ+ people? Why?

8. What do you think is the best approach for services for LGBTQ+ people – specialist services or mainstream services that meet LGBTQ+ need? Why?

a) What can mainstream services do to be more LGBTQ+ inclusive?

Appendix C

Questions used to guide professionals' focus group

1. What kind of work have you done to support people engaged in chemsex?

2. Is work with people engaged in chemsex any different to the work your service usually does? If so, how?

- a) Is it easier? Or more complex?
- b) Has it got any easier, or is it becoming harder/more complex?

3. Do you feel confident working with people engaged in chemsex? Why?

- a) What issues does it bring up for you as a healthcare professional?

4. How confident do you think your clients are to talk openly and honestly about their engagement in chemsex?

- a) What issues does it bring up for clients?

5. What related issues do clients discuss?

- a) What do you do with this?
- b) Do you know how to respond?

6. What is your experience of referring clients for additional support?

- a) Where would you refer them?
- b) Do they take up the referral?
- c) Do you/they encounter any barriers? If so, how can we help overcome them?

7. In an ideal world how do you think clients would best like to be supported?

- a) Please think about where, how, when, what kind of service, what kind of intervention etc.

8. Is there anything else you want to mention?

Appendix D

Additional relevant research and resources

There are some additional recent and upcoming reports and research that can further understanding of drug use and chemsex within LGBTQ+ populations and how to improve services for them.

The Love Tank

The Love Tank is a Community Interest Company who undertake a wide range of research into queer people's health; provide harm reduction resources around drugs; and run programmes across London. They have published two needs assessments of queer people's drug and alcohol needs which can be accessed at www.thelovetank.info/research

They are also running Sex, Drugs and Care For All, an innovative peer mobilisers harm reduction outreach programme in partnership with Antidote: www.thelovetank.info/sdc4all

Antidote has worked with The Love Tank to produce a new range of harm reduction resources: www.queerhealth.info/projects/sdc4all

Gay Men's Health Collective (GMHC)

GMHC provides a wide range of harm reduction materials and information at gaymenshealthcollective.co.uk

They have delivered a programme of conference in London from 2024 – 26. Antidote has partnered with them on some of these. Conference reports are available:

2024 Report: gaymenshealthcollective.co.uk/london-chemsex-conference-2024

2025 – 26 Report: gaymenshealthcollective.co.uk/london-chemsex-conference-2025

You Are Loved chemsex survey

The LGBTQ+ Community Interest Company You Are Loved has recently completed a survey examining drug use and chemsex within LGBTQ+ populations across London, in partnership with Public Health in the London Boroughs of Lambeth, Southwark, and Lewisham.

This report will be published in Spring 2026. youareloved.org.uk

ACMD LGBT+ and Chemsex Report

The Advisory Council on the Misuse of Drugs is working on a report on drug use and chemsex in LGBT+ communities and ran an open call for evidence which closed in January 2026.

Their report is expected later in 2026. www.gov.uk/government/calls-for-evidence/drug-use-in-lgbt-communities-and-chemsex



**EXAMINING THE DRUG, ALCOHOL,
AND CHEMSEX EXPERIENCES OF
LGBTQ+ PEOPLE AND THE
HEALTHCARE STAFF
SUPPORTING THEM**