

ACMD Drug Use in LGBT+ Communities and Chemsex Report: Call for Evidence

Please consider the following information before completing the questionnaire:

Completing the questionnaire

Although your expertise may be better suited to only a subset of the following questions, it would be helpful if you were to consider every question in the questionnaire.

Where possible, please provide supporting evidence and references in your response. The ACMD considers a wide range of evidence as part of its advice, including published literature, statistics, data from UK organisations and expert and interest holder opinions.

Please return your submission to the ACMD Secretariat at: acmd@homeoffice.gov.uk.

How we will use your information

Respondents should note that evidence submitted will inform the development of recommendations from the ACMD and could ultimately be published. However, in the interest of confidentiality and protecting commercial interests, any information submitted will be non-attributable.

All data submitted in response to this call for evidence will be protected by the ACMD Secretariat in accordance with the UK General Data Protection Regulation (UK GDPR). Furthermore, Section 43(1) of the Freedom of Information Act provides an exemption for information which is a trade secret, whilst Section 43(2) exempts information whose disclosure would, or would be likely to, prejudice the commercial interests of any person (an individual, a company, the public authority itself or any other legal entity).

Section 1: About yourself / your organisation

Q1a) Please indicate below if the following statement is applicable:

"My submission should be considered a personal response reflecting my professional experience in this area and therefore not representative of the organisation I work for."

"My submission should be considered as representative of the organisation I work for."

Q1b) Please describe either the nature of your organisation and your role or your personal expertise within this area:

Q1c) (For healthcare professionals only)

Please select the setting in which you work: Primary care (e.g. GP practice) Secondary care (e.g. general hospital) Specialist mental health services Addiction services Other community-based services (please specify) Other (please specify)

The Royal Pharmaceutical Society (RPS) welcomes the opportunity to contribute to the ACMD's call for evidence on drug use in LGBT+ communities and chemsex. As the professional leadership body representing pharmacists, pharmaceutical scientists and pharmacy practice across Great Britain, we champion excellence in medicines use and advocate for high-quality, equitable healthcare for all. Our mission is to put pharmacy at the forefront of patient care to ensure the safe and effective use of medicines and support the profession for the benefit of patients and the public.

Our expertise includes frontline healthcare provision, medication management, harm reduction, and public health interventions. We are committed to enhancing the role of pharmacists in addressing complex health issues, including drug use in vulnerable communities such as LGBT+ populations engaged in chemsex.

This submission should be considered as representative of the RPS as an organisation. Our response draws on the available evidence base as well as the expertise of pharmacists who work across community, primary care, specialist services, mental health and public health.

Section 2: Community context and observation

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

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

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

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

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

Recreational drug use within LGBT+ communities encompasses a broad range of substances, with chemsex contexts most commonly involving crystal methamphetamine, gamma-hydroxybutyric acid/gamma-butyrolactone (GHB/GBL), mephedrone, cocaine, ketamine, amphetamine, ecstasy/MDMA, alkyl nitrites (“poppers”) and cannabis. These substances are typically consumed via oral ingestion, nasal insufflation and injecting (“slamming”), often in combination, which substantially increases health risk ([Schifano et al., 2025](#); [Georgiadis et al., 2025](#), [Bouëdec et al., 2025](#)).

National and parliamentary evidence consistently demonstrates that LGBT+ people experience a markedly higher prevalence of drug use than the general population, with chemsex disproportionately affecting gay, bisexual and other men who have sex with men (MSM). Urban centres with established LGBT+ communities, particularly London and other large cities, report higher prevalence of chemsex-related harms, reflecting both population density and service visibility ([Croydon Council, 2023](#); [London Ambulance Service, 2023](#)). Although robust and consistent UK-wide surveillance is limited, written evidence submitted by the LGBT Foundation to the UK Parliament highlights elevated levels of sexualised drug use, associated sexual risk-taking (including low condom use and multiple partners), and the role of minority stress, discrimination and hate crime as key drivers of drug use and social harm ([LGBT Foundation, 2019](#)).

Evidence suggests that chemsex practices are most prevalent among younger MSM, with important demographic gradients related to ethnicity, socioeconomic status and geography, and with emerging concerns extending beyond the MSM community, including transgender and non-binary people who are frequently underserved by mainstream services ([Georgiadis et al., 2025](#); [Ramazanova et al., 2025](#); [Bouëdec et al., 2025](#)). Despite this, there remains insufficient, consistent

UK-wide surveillance capturing sexual orientation and gender identity in drug use datasets, limiting understanding of prevalence and trends across all LGBT+ sub-groups, particularly trans and gender-diverse people ([Roberts et al., 2025](#)).

Pharmacists, as highly accessible frontline healthcare professionals, are well positioned across a variety of relevant sectors of practice to observe emerging patterns such as increasing polydrug use, novel psychoactive substances and medicine-related harms through routine interactions. In community pharmacy this can be through emergency supply, needle and syringe exchange programmes and informal consultations. However, these observations are rarely captured within formal surveillance systems, representing a missed opportunity to inform early warning, prevention and service planning, through community-based intelligence ([Guirguis, 2022](#)). In other settings, pharmacists will observe emerging patterns of polydrug use and harm through formal consultations and pharmaceutical care provision in acute medicine/emergency departments (ED), community and specialist mental health teams and sexual health services.

Section 3: Perceived harms and health impacts

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

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

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

Chemsex and related patterns of drug use are associated with substantial and intersecting physical, psychological and social harms ([Bouëdec et al., 2025](#)). Recent UK expert consensus highlights harms including overdose, acute toxicity, psychosis, blood-borne virus transmission, sexual assault, relationship breakdown, housing instability and criminal justice involvement ([Hillier et al., 2024](#)). Acute harms are increasingly visible to emergency services. London Ambulance Service reports at least one chemsex-related call-out per day, most commonly involving GHB/GBL and crystal meth, with presentations including respiratory depression, seizures and loss of consciousness ([London Ambulance Service, 2023](#)).

Polydrug use is a defining feature of chemsex and significantly increases risk through pharmacokinetic and pharmacodynamic interactions, including serotonergic toxicity, sympathomimetic overstimulation and seizures. These complex exposure patterns are associated with longer-term trajectories of harm, including subsequent misuse of opioids, gabapentinoids and other medicines, reflecting attempts to manage comedown effects, mental distress and sleep disruption ([Schifano et al., 2025](#); [Platteau et al., 2025](#)).

Mental health harms are highly prevalent and include anxiety, depression, trauma, suicidal ideation and co-occurring psychiatric disorders, often driven by experiences of homophobia, transphobia, victimisation and social isolation ([Murray et al., 2024](#); [Dimova et al., 2022](#)). Substance use patterns in LGBT+ communities are linked with minority stress - the chronic social

stress experienced due to stigma, discrimination and structural inequalities - rather than intrinsic behaviour. This has been demonstrated in multiple UK and international studies, reinforcing that drug-related harms must be addressed within broader psychosocial and public health frameworks (Metheny et al., 2024). UK-specific data shows high prevalence of chemsex-related substances (e.g., GHB/GBL, synthetic cathinones, methamphetamine) and significant mental health impacts including elevated anxiety and depression among weekly chemsex users, indicating unmet needs for targeted interventions (Davies et al., 2025).

Pharmacists are well positioned across a variety of relevant care settings to encounter these harms through medicine-related interactions, needle and syringe exchange programmes, emergency supply requests and both formal and informal consultations. These interventions place pharmacy teams at a critical point for early identification of risk, harm-reduction advice and onward referral. However, documented gaps in training related to chemsex, LGBT+ health and trauma-informed care currently limit pharmacists' ability to respond consistently to these complex and intersecting needs (Guirguis, 2022; Brighton & Hove LGBTQ Switchboard, 2017).

Community pharmacies also act as accessible points of contact for people experiencing mental distress, including anxiety, low mood and sleep disturbance, particularly in relation to medicines use. National professional guidance recognises pharmacists' roles in medicines optimisation, brief supportive conversations and signposting to primary care and mental health services (Royal Pharmaceutical Society, 2022). Given the high prevalence of co-occurring mental health difficulties among LGBT+ people who engage in chemsex, community pharmacy represents an important, though under-recognised, setting for early engagement rather than a substitute for specialist mental health or substance misuse care.

Section 4: Access to services and support

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

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

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

Support for LGBT+ people experiencing drug-related harms is delivered through a fragmented patchwork of sexual health clinics, specialist drug and alcohol services, LGBT-specific community organisations and, less formally recognised, community pharmacies. Evidence consistently shows that many LGBT+ people delay or avoid mainstream drug and alcohol services due to anticipated or experienced stigma, lack of LGBT-competent staff, heteronormative service environments and concerns about confidentiality (LGBT Foundation, 2019; Murray et al., 2024). Qualitative research in London highlights barriers to uptake of harm reduction within social venues, pointing to unmet needs for tailored interventions and coordinated partnerships with local policy and healthcare

systems ([Naulls et al., 2025](#)).

Pharmacists play a vital and multifaceted role in the delivery of sexual, reproductive, and broader primary healthcare—particularly for LGBT+ people, who often experience distinctive health challenges, access barriers, and stigma. These highly trained clinicians contribute in several key settings. In sexual health services, pharmacists based in specialist sexual health clinics are integral to prevention, screening, medicine management and monitoring. In some areas, sexually transmitted infections (STI) screening is a commissioned service from community pharmacy. ([NHS England, 2024](#)) Pharmacists in a variety of relevant care settings provide evidence-based medication advice to LGBT+ people including advice on PrEP/PEP and hormone therapy.

Community pharmacies offer accessible harm-reduction services, including needle and syringe exchange programmes, overdose prevention advice and referral to specialist care. UK public health guidance recognises the role of pharmacy teams in delivering substance misuse services, providing sterile injecting equipment and offering harm-reduction advice within local pathways ([Office for Health Improvement & Disparities, 2024](#); [NICE PH52, 2014](#)). For individuals concerned about stigma, disclosure or engagement with specialist services, pharmacies may represent a lower-threshold, familiar and relatively anonymous point of contact.

Despite this, pharmacists' roles remain under-recognised and under-utilised within substance misuse pathways, particularly for chemsex-related harms. Evidence from LGBT+ community research indicates that pharmacy staff often lack training in LGBT+ health and inclusive practice, which can undermine trust and limit effective engagement ([Brighton & Hove LGBTQ Switchboard, 2017](#); [Guirguis, 2022](#)).

Pharmacy teams, when appropriately trained, have the potential to reduce barriers by offering non-judgemental, culturally competent environments, proactive signposting and early intervention, particularly for individuals who are not yet engaged with specialist services ([Guirguis, 2022](#), [Navarette, 2021](#)).

Section 5: Interventions and harm reduction

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

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

*Q5c) Do you feel that individuals engaging in chemsex are adequately **informed about the risks** of chemsex and harm reduction strategies? What **educational resources or campaigns** do you think would be beneficial?*

A recent systematic review of chemsex intervention strategies demonstrates diverse approaches but underscores a lack of clear consensus on effectiveness, indicating a need for innovative models and evaluation frameworks that include community health providers ([Íncera-Fernández,](#)

2025). Research on affirming substance use services highlights the central role of culturally competent care in improving service engagement, especially among LGBT+ people who experience stigma in mainstream systems (Paschen-Wolff et al., 2024). Despite the breadth of chemsex-focused interventions described in the literature, there is limited consideration of how existing community health infrastructure, including community pharmacy, could be systematically integrated into harm-reduction and early-intervention models.

Evidence increasingly supports LGBT-affirming, community-embedded harm reduction and recovery models as best practice, although coverage and evaluation remain inconsistent across the UK (Mental Health Research UK, 2025; LGBT Foundation, 2024). Effective interventions include peer-led support, trauma-informed psychosocial approaches, safer sex and safer drug-use education, and integrated responses that address mental health, substance use and social stressors together (Hillier et al., 2024).

Emerging research also demonstrates the feasibility and acceptability of digital harm-reduction tools co-designed with community members, underscoring the importance of tailored, accessible resources for people who engage in chemsex (Meyer et al., 2025). Formative evidence shows that peer-led chemsex interventions can be acceptable and feasible but require structured training, support and integration with clinical services, underscoring the need for coordinated referral pathways from community settings, such as pharmacies (Freestone et al., 2025).

Pharmacists can contribute meaningfully to harm reduction through provision of needle and syringe programmes, advice on drug–drug interactions (including interactions with HIV and gender-affirming therapies), brief harm-reduction conversations and referral into specialist services. However, individuals engaging in chemsex are not consistently adequately informed about risks or harm-reduction strategies, highlighting the need for improved, accessible education delivered across multiple settings, including community pharmacy (Guirguis, 2022). Targeted training, co-designed educational resources and formal inclusion of pharmacy within local chemsex harm-reduction pathways would enable pharmacy teams to deliver more consistent, visible and inclusive harm-reduction support, particularly for individuals not yet engaged with specialist services.

The LGBT Foundation has developed training to equip community pharmacy teams to provide inclusive care for LGBT+ people through inclusive practice. (Pride in Practice, 2022)

Section 6: Recommendations

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

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

Q6c) What would make **general population services** (e.g., mental health services, addiction services, sexual health services etc.) more accessible, welcoming or safe to LGBT+ individuals?

Q6d) Do you feel that there are any **areas of research** relating to drug use within LGBT+ communities including chemsex which are lacking data, or where further research would be beneficial?

Evidence strongly supports expanding and formalising the role of pharmacists within public-health

responses, including mental health support related to medicines use and harm reduction. However, pharmacists' contributions to addressing chemsex-related harms in LGBT+ communities remain largely absent from policy, commissioning and research. We, therefore, recommend:

- Formal recognition of pharmacists, practicing across all care settings, as part of multidisciplinary responses to chemsex-related harms.
- Further support for targeted training to build capacity among healthcare professionals, particularly pharmacists, in LGBT+ cultural competence, chemsex, trauma-informed care and relevant pharmacology across undergraduate and continuing professional development.
- Clear referral pathways linking community pharmacies with sexual health, mental health and specialist substance misuse services.
- Visible inclusion measures in general population services to reduce stigma and improve safety for LGBT+ individuals.
- Improved data collection on sexual orientation and gender identity in drug treatment, emergency and mortality datasets.
- Dedicated research evaluating pharmacy-based harm reduction models for LGBT+ communities.

Reducing stigma, fragmentation and invisibility within services is essential. Integrated, multidisciplinary approaches remain key to addressing the complex and cumulative harms associated with chemsex and substance use in LGBT+ communities ([Schifano et al., 2025](#); [Hillier et al., 2024](#)).

Embedding pharmacists within chemsex harm-reduction pathways aligns with broader UK health inclusion strategies, including NHS commitments to LGBT+ health equity and culturally competent care, and with recent calls for health systems to address intersectional harms (Healthcare Commission frameworks and ACMD priorities). Although the literature robustly discusses chemsex harms and intervention approaches, there is a clear gap in evidence regarding the role of community pharmacy and pharmacists. This gap reflects historic under-recognition rather than lack of potential, and major research agendas (including intervention research and services evaluation) should explicitly include pharmacy settings as a key site of harm-reduction and early engagement.

Section 7: Any other comments

Please include any information such as relevant links to webpages, reports, or international projects in progress.

If you would be happy for us to get in touch to further discuss your responses, please leave a contact address – this is optional, and any responses published will be non-attributable: