

Substance use needs assessment

Chemsex & sexualised drug use

June 2026

Authors

This report was written by Drew Hawkinson (Public Health Analyst) and Anthony Blissett (Public Health Registrar).

Report approvers

This report was approved by Andrew Trathen (Public Health Consultant), Simon Young (Principal Public Health Specialist), and Diana Divajeva (Assistant Director for Public Health Insight and Strategic Planning).

Acknowledgements

We would like to sincerely thank the following organisations for their contributions to this report: City and Hackney Recovery Service, Controlling Chemsex, Gay Men's Health Collective, Homerton Sexual Health Services, London Friend, Metropolitan Police Service, Open Doors, Project Sagamore, Safe Only Ltd, Survivors UK, The Havens, The Love Tank, UK Health Security Agency, We Are With You UK.

Cite this report as:

City and Hackney Public Health. Substance use needs assessment: chemsex and sexualised drug use. (June 2026).

Version control

Version 4.0, published June 2026.

Content

Executive summary	3
City and Hackney Public Health anti-racist and structural inequalities statement	7
Abbreviations and acronyms	8
Glossary of terms	10
1. Introduction	11
2. Policy context	15
3. Methods	18
4. Findings	22
4.1 Prevalence and demographics	22
4.2 Practices	33
4.3 Health risks and harms	40
4.4 Social risks and harms	52
4.5 Harm reduction and support services	56
5. Conclusions	65
6. Recommendations	69
Policy and programming	69
Data collection	74
References	77
Appendix 1: Literature review search terms	84
Appendix 2: Sensitivity analysis of SHL data	85
Appendix 3: Aggregation of ethnicity data from SHL	91

Executive summary

This report accompanies the larger substance use needs assessment and provides an initial exploration of chemsex—a specific subtype of sexualised drug use (SDU) often associated with gay, bisexual, and other men who have sex with men (GBMSM) and other lesbian, gay, bisexual, transgender, and other queer communities (LGBTQ+). The report analyses local activity, associated harms, and the service landscape in the City of London (City) and the London Borough of Hackney (Hackney) to inform public health recommendations.

Background

Chemsex is defined by the use of 'chems'—historically methamphetamine, gamma hydroxybutyrate/gamma butyrolactone (GHB/GBL), and mephedrone—to enhance, sustain, or facilitate sexual experiences. While some participants find the practice manageable and pleasurable, others can face severe risks, including poor mental health, physical and psychological dependence, and in rare cases, death. Historically rooted in London's nightclub scene, chemsex is now primarily facilitated through digital platforms and geosocial networking apps.

Motivations for engaging in chemsex are complex, ranging from physical pleasure and increased intimacy to coping mechanisms for internalised homophobia, social isolation, and stigma. Professionals have diverse views on how best to address the public health impact of chemsex: some focus on the need for community-based approaches to equip people who engage in chemsex with tools to reduce harm, while others favour more rehabilitative and abstinence-based approaches given the risk of physical, mental, and social harms.

Policy context

Chemsex is increasingly recognised as a public health concern, though national policy focus remains limited.

- **National recognition:** Chemsex has not featured prominently in national strategies or received much political attention outside of a few high-profile examples of chemsex-related crime. The UK 10-year drugs plan mentions chemsex only twice, focusing primarily on heroin and crack cocaine. However, the 2025 HIV Action Plan for England recommends stronger links between sexual health, substance use, and mental health services to support individuals engaged in chemsex to reduce disengagement from HIV care and HIV transmission.
- **Local drivers:** The City & Hackney Combating Drugs Partnership (CDP) and the local Sexual and Reproductive Health Strategy (2024-2029) prioritise early, targeted support and bespoke harm reduction for people who engage in chemsex.

Methods

This needs assessment took a three-pronged approach to analyse relevant data and determine local insights:

- **Literature review:** A scoping search and systematic review of over 130 relevant articles and grey literature.
- **Quantitative research:** Data were gathered from the online sexual health testing provider, Sexual Health London (SHL), and local service providers: Antidote and Homerton Sexual Health Services (HSHS). Notably, national datasets like GUMCAD and NDTMS were excluded due to incomplete or imprecise data regarding chemsex activity.
- **Qualitative research:** 18 semi-structured interviews were conducted with professionals across the NHS, police, and voluntary sectors to triangulate and expand on findings. Interviews were not conducted with individuals who engage in chemsex due to ethical concerns.

Findings

Prevalence and demographics

Global literature estimates that approximately 10-20% of GBMSM may be engaging in chemsex at any given point in time, with prevalence greater in more urban areas like London. Based on Census data, this suggests between 845 and 1,691 individuals in Hackney and 44 to 88 in the City may be engaging in chemsex. Data from local services shows that participants are predominantly white, cisgender men aged 25-44. Participation in chemsex is strongly associated with participation in sex work.

Practices

Methamphetamine and GHB/GBL are the most common substances used locally. Polydrug use is prevalent. A minority of individuals (4.7-20%) in City and Hackney may inject chems, a practice associated with higher risk of drug dependence and health harms.

Health and social risks and harms

There is limited data to estimate the burden of chemsex-related health and social harms in City and Hackney. However quantitative and qualitative data point to the following insights:

- **Physical and sexual health:** Chemsex is associated with 1.28 times higher odds of gonorrhoea acquisition locally, though not necessarily associated with acquisition of other STIs. Participation in chemsex can have a negative impact on individuals' physical and sexual health, such as decreased adherence to HIV medication, overdose, and other harms.

- **Mental health:** There is a significant burden of unmet need amongst people engaged in chemsex and services are not equipped or willing to meet this need. Chemsex is strongly associated with poor mental health, including paranoia, psychosis, and suicidal ideation.
- **Social harms:** People who engage in chemsex may be at increased risk of experiencing work-related problems, homelessness, sexual assault, domestic abuse, and exploitation. Victims of chemsex-related crime often do not report crimes to the police due to fear of stigma or self-incrimination.

Needs and challenges

City and Hackney has more robust chemsex support and harm reduction services than other areas of London; however, significant challenges remain:

- **Capacity:** Local chemsex support services do not have enough staff or skills, especially in treating more severe mental health needs like psychosis and trauma, to meet the increasing complexity of individuals needing support for chemsex. There is an increasing need to invest in community-based harm reduction services for chemsex.
- **Coordination:** Given the highly mobile nature of chemsex and the differences in eligibility for services based on area of residence, services face challenges trying to coordinate care for individuals with complex health and social needs across multiple statutory services.
- **Gaps:** There is limited mental health support for individuals with co-occurring mental illness and substance use due to exclusionary criteria in services. Availability of bespoke chemsex support varies across London, meaning that individuals who interact with services in City and Hackney may be lost to care if referred to services in other local authorities. Conversely, individuals who are seen at open access sexual health services outside of City and Hackney may not be linked to local support services. Generally, there are gaps in the provision of bespoke chemsex support and harm reduction services across London, such as inpatient detoxification for GHB/GBL and residential rehabilitation.
- **Inequalities:** White, cisgender, gay men may be over-represented in support services, largely due to historical association of chemsex with this community and stigma felt by other communities, such as transgender individuals and individuals from black and global majority ethnic groups.
- **Data Limitations:** Health and social services lack data fields that appropriately capture chemsex activity, making it difficult to monitor service impact or precisely map community needs. For example, there is no current clinical code for chemsex-related mental and behavioural disorders, meaning that hospitals are unable to effectively monitor chemsex-related hospitalisations.

Recommendations

This needs assessment provides initial local insights on an increasingly complex and dynamic subtype of substance use. Using these insights, Public Health has developed the following recommendations:

Policy and programming	
1.	Adopt a holistic service approach with increased support for complex mental health needs such as psychosis and trauma
2.	Explore cross-sector commissioning opportunities between substance use, sexual health, and mental health
3.	Improve accessibility and acceptability of services for black and global majority ethnic communities and transgender and gender nonconforming individuals
4.	Strengthen referral pathways between disparate providers
5.	Explore pan-London partnerships to coordinate response
6.	Train front-line staff in ambulance services, accident and emergency, secondary mental health services, homelessness, law enforcement, social care, drug and alcohol services, and sexual health on chemsex awareness, response, and cultural competence
7.	Increase outreach on sex and dating platforms and nightlife venues
8.	Increase knowledge and awareness of the risks of chems use, specifically GHB overdose, methamphetamine-induced psychosis, and sexual assault
9.	Develop and expand community-based harm reduction and risk management interventions
Data collection	
1.	Increase local knowledge through community engagement and research
2.	Improve data collection amongst local services
3.	Revise triage questions in the online STI kit ordering service to improve data collection
4.	Develop chemsex-specific fields for relevant local, regional, and national databases

These recommendations represent several actions to support individuals engaged in chemsex and reduce chemsex-related harms. Findings and recommendations in this needs assessment are limited, however, by the lack of high quality data on the profile and needs of individuals in City and Hackney engaged in chemsex overall, especially those not engaged in support services. This topic should be revisited in the future once data limitations have been addressed and a more comprehensive review is possible.

City and Hackney Public Health anti-racist and structural inequalities statement

Differences shown by characteristics such as ethnicity or deprivation reflect unequal living conditions shaped by structural factors, including poverty, racism, access to housing, education and employment, access to and experience of healthcare, and greater exposure to harm such as crime, environmental risks, unsafe housing, or financial insecurity. As such they should not be interpreted as natural, unavoidable or expected.

When data are broken down by a single characteristic, they show only part of a much more complex picture. For example, patterns by deprivation often reflect a social gradient, meaning that people living in more disadvantaged circumstances tend to experience worse health and shorter lives than those who are more advantaged. Differences by ethnicity frequently reflect the impact of systemic racism and wider structural inequalities, rather than ethnicity itself.

These findings should always be interpreted in context and alongside other evidence, including qualitative insight and lived experience. They are intended not only to support understanding of structural inequality, but to inform action: shaping local public health policy, strategy, service design and decision making in ways that reduce inequality and target the underlying causes affecting groups most impacted.

Abbreviations and acronyms

ADHD - attention deficit/hyperactivity disorder

CDP - Combating Drugs Partnership

CI - 95% confidence interval

City - City of London

COPD - chronic obstructive pulmonary disease

DHSC - Department of Health and Social Care

DoxyPEP - doxycycline used as post-exposure prophylaxis for chlamydia and syphilis

DPH - Director of Public Health

ELD - East London Database

ELFT - East London Foundation Trust

FY - financial year (1st April - 31st March)

GBL - gamma butyrolactone, a prodrug of gamma hydroxybutyrate

GHB - gamma hydroxybutyrate

GBMSM - gay, bisexual, and other men who have sex with men

GBMSM+TGNC - gay, bisexual, and other men who have sex with men and transgender and gender nonconforming individuals who have sex with men

GMHC - Gay Men's Health Collective

GUMCAD - Genitourinary Medicine Clinic Activity Dataset

Hackney - London Borough of Hackney

HBV - hepatitis B

HCV - hepatitis C

HES - Hospital Episode Statistics

HIV - human immunodeficiency virus

HMPPS - HM Prison and Probation Service

HSHS - Homerton Sexual Health Services

ICB - Integrated Care Board

JSNA - Joint Strategic Needs Assessment

LAS - London Ambulance Service

LGBTQ+ - lesbian, gay, bisexual, transgender, queer, and other identities

LSOA - Lower Super Output Area

MDMA - 3,4-methylenedioxyamphetamine

MPS - Metropolitan Police Service

NDTMS - National Drug Treatment Monitoring System

NHS - National Health Service

ONS - Office of National Statistics

PEP - post-exposure prophylaxis for HIV

PrEP - pre-exposure prophylaxis for HIV

SARC - sexual assault referral centre

SDU - sexualised drug use

SHL - Sexual Health London

SHRAD - Sexual and Reproductive Health Activity Dataset

UKHSA - United Kingdom Health Security Agency

VCS - voluntary and community sector

Glossary of terms

95% confidence interval - The range of values in which there is 95% confidence that the true value lies.

Chemsex - A term used to describe a type of sexualised drug use that is historically associated with gay, bisexual, and other men who have sex with men, typically involving the sexualised use of methamphetamine, GHB/GBL, and/or mephedrone.

Incidence - The occurrence, rate, or frequency of a specific event over a specific period of time.

Lower Super Output Area - Small, consistent, and comparable geographic units used for statistical analysis in England and Wales for data on deprivation and health.

Positivity rate - The proportion of tests with a positive result.

Prevalence - The proportion of individuals who engage in a specific behaviour or have a specific attribute at one point in time.

Sensitivity analysis - A statistical technique that measures the impact that different types of uncertainty in datasets have on the reliability of results. Sensitivity analyses can test the robustness and validity of methods to control for uncertainty by seeing if results remain stable.

Serosorting - A risk-reduction strategy where individuals select sexual partners with the same known HIV status to engage in unprotected sex.

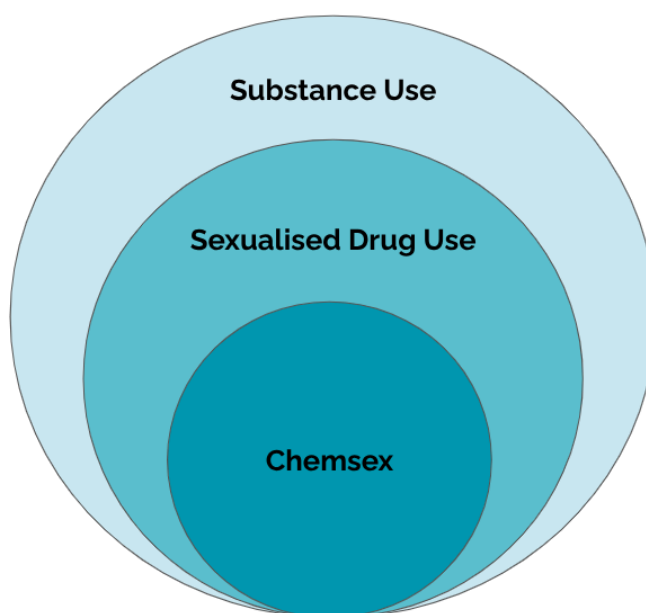
Sexualised drug use - The intentional use of psychoactive substances before or during sexual activity to enhance, sustain, or facilitate the experience.

Slamming/slamsex - A term used to refer to injection drug use during chemsex.

1. Introduction

Chemsex is a subtype of substance use and sexualised drug use (SDU) traditionally associated with gay, bisexual, and other men who have sex with men (GBMSM) in which psychoactive substances, referred to as “chems”, are used to enhance, sustain and facilitate sexual experiences (Figure 1) (1).

Figure 1. Diagram showing the relationship between substance use, sexualised drug use and chemsex.



Historically, chemsex referred to the use of any combination of three specific substances: methamphetamine, GHB/GBL and mephedrone (Table 1) (1–3). However, other drugs, such as cocaine, MDMA or alkyl nitrate (‘poppers’) may also be used during chemsex (2–5). In recent years, ketamine use has become more common in chemsex settings due to its dissociative effects. Polydrug use is common in chemsex settings (2,3,5,6). A subset of individuals engaged in chemsex inject chems, usually methamphetamines or mephedrone, as part of their practice, which is termed “slamming” (2,7).

Importantly, while the term chemsex has primarily been associated with GBMSM, the wider community of people who identify as lesbian, gay, bisexual, transgender, queer and more (LGBTQ+)—in particular, transgender and gender nonconforming individuals who have sex with men—also engage in chemsex, often in the same settings. Furthermore, recent research and reports have given increased attention to the use of chems in sexual contexts by people who do not identify as LGBTQ+, such as heterosexual men and women, to enhance, sustain and facilitate sexual experiences (8). As such, there is ongoing debate amongst researchers and professionals as to exactly how chemsex is defined and what drugs, sexual activities, and population groups it should include, and sometimes terms are used interchangeably (4). However, while quantitative

data on relative prevalence of chemsex and sexualised drug use amongst different population subgroups is lacking, researchers acknowledge that chemsex and sexualised drug use is more pronounced amongst GBMSM and other LGBTQ+ groups.

Table 1 provides a more in-depth description of the three main drugs included in chemsex.

Table 1. Basic information on the three main drugs used in chemsex.

	Methamphetamine	GHB/GBL	Mephedrone
Informal names	Crystal, Meth, T, Tina, Ice	G, GHB, GBL, Gina, Liquid ecstasy	Meph, Drone, M-Cat, Meow meow
Appearance	White / off white tablets, powders or crystals	Colourless oily liquid. Rarely a capsule or powder. GHB has no smell and a salty/soapy taste. GBL has a strong chemical smell and taste.	Very fine white, off white or yellow powder. Tastes and smells foul and metallic.
Type of drug	Strong CNS stimulant	CNS depressant	CNS stimulant
Routes of administration	Swallowed (in 'bombs'), snorted, injected, or rectally administered ('booty bumping/boofing')	Swallowed (mixed in a drink). Rarely injected or snorted powdered forms	Swallowed (in 'bombs'), snorted, injected, or rectally administered ('booty bumping/boofing')
Main effects	Alert, aroused, exhilarated, reduced inhibitions	Euphoria, drowsiness, relaxed, aroused, reduced inhibitions	Alert, euphoric, hypersensitive, hyper-affectionate
Duration	Rapid onset. Lasts 4-12 hours	Onset 10-120 minutes Lasts several hours	Rapid onset. Can last for several hours with side effects lasting days.
Legal status	Class A	Class B	Class B

Note: GBL is a prodrug that metabolises into GHB when consumed. GBL is two to three times more potent than GHB.

The origins of chemsex can be traced back to the end of the 20th century, primarily within the gay nightclub scene in metropolitan areas like London (1). Initially, the use of drugs in this context was perceived as a means to enhance socialisation and alleviate inhibitions. Currently, chemsex is seen as a distinct subculture amongst GBMSM+TGNC characterised by the integration of chems into sexual encounters, often occurring within group settings and enabled

by a rapid rise in digital hook up platforms, like Grindr (1–3,6). Many people who engage in chemsex refer to it using other terms, such as 'chillouts', 'chill fun', or 'party 'n play' (4,6). Researchers describe many different reasons for participating in chemsex, listed in Table 2 (2,3,9–12).

Table 2. Reported reasons for participating in chemsex.

Sexual	Psychological	Social
Increased libido	Dependence	Increased intimacy
Sexual satisfaction	Overcoming inhibitions	Peer pressure
Coping for sexual dysfunction	Loneliness	Sense of community
Physical pleasure	Escapism	Normalised behaviour
Inability to have sober sex	Coping for mental health needs	Exploitation
	Stigma and shame around sex	

People are most commonly introduced to chems through friends, acquaintances, or partners as a form of socialising and/or through exposure to chemsex on digital hook up platforms (2,9,13,14). Historically, chemsex was viewed as a way for GBMSM+TGNC to re-establish sex as a pleasurable and intimate act after experiencing decades of trauma, stigma, and shame surrounding sex during the height of the HIV/AIDS epidemic and social condemnation of homosexuality and queer identities (1,2). This sentiment is still present amongst GBMSM+TGNC who practise chemsex today; chemsex has continued to proliferate GBMSM+TGNC communities because it is seen by many as an enjoyable form of sexual expression and liberation (9,11). At the same time, some researchers note that engagement in chemsex can be viewed as a maladaptive coping mechanism, motivated by a complex mixture of shame, stigma, social isolation, lack of community, adverse childhood experiences, self-loathing, perceived lack of physical or sexual attractiveness, and internalised homophobia (15,16).

The scope of activity amongst people who engage in chemsex is vast and care needs to be taken to ensure that system responses are proportionate to these diverse levels of need and harm. For some, chemsex may be a manageable sexual practice with perceived psychosexual benefits and limited consequences (4,11,17). Others can find it increasingly difficult to maintain control over their relationship with chemsex and may experience personal health and social risks, including dependence (2,12,18–21). Professionals note that this dependence can be both to the chems themselves and to the psychosexual and social experience of chemsex, leading men to feel they cannot leave groups where chems use is normalised, even when they want to, as it would mean losing their support network and ability to enjoy sex (4,22,23). This can lead to

cycles of increasing engagement in chemsex, increasing dependency, and worsening personal circumstances.

The community of professionals and individuals engaged in chemsex hold a range of positions on the severity of chemsex-related harms. Some believe chemsex has been mislabelled as a “crisis”, with public interest being driven by rare cases of chemsex-related murder, distracting from proportional focus on building community bonds and encouraging harm reduction measures (4). Others believe that there is no safe way to engage in any form of chemsex and a zero tolerance, abstinence approach is the only way to prevent inevitable harms of chemsex, which include dependency, sexual assault, and deterioration of physical and mental health (4). What is universally agreed is that chemsex has become an increasing public health concern in recent years and there are significant health and social needs associated with chemsex that are currently not being addressed (24). This was made apparent in a recent report from the Office of National Statistics, which showed that the risk of death due to drug poisoning in the England and Wales (including outside of chemsex context contexts) was 2.8 times higher in people identifying as LGB+ compared to straight/heterosexual people, with LGB+ males having the highest age-standardised rate of death due to drug poisoning (30.1 per 100,00 people) (25). While the negative impacts of chemsex are commonly understood by the community and professionals who specialise in chemsex support, chemsex remains poorly understood by the general population of professionals working in health and social care sectors (24).

This needs assessment aims to take an initial look at chemsex in the City of London (City) and London Borough of Hackney (Hackney) and explore its many interrelated aspects from a public health perspective. By assessing current local information about chemsex activity, related harms, and the needs of those engaging in chemsex, as well as the landscape of local chemsex-specific services, this report makes recommendations on how to reduce chemsex-related harms in City and Hackney and improve support for individuals engaged in chemsex.

2. Policy context

Chemsex is considered a rising phenomenon by most professionals working in substance use, sexual health, and other related fields (2,3,5,24). There is still, however, a lack of research into effective interventions to reduce chemsex-related harm. Professional momentum has started to build in recent years in response to the unique health and criminal justice challenges chemsex presents, driven by its occasional coverage on mainstream media (14,26–28). This has led to the creation of cross-sector working groups in London at the local, regional, and pan-London levels. The service-level health response, however, has remained somewhat subdued, with very limited quantitative data or literature synthesis specific to London, it is challenging to accurately determine population need and adjust services accordingly. Most of the support for people who engage in chemsex is provided by voluntary and community sector (VCS) organisations, local substance use support services, or NHS sexual health services, with a focus on talking therapies, group sessions, information dissemination, and harm reduction.

Political recognition

Chemsex has largely remained on the fringe of political discourse with the exception of a few distinct events that drew media attention. Most notable was the case of Stephen Port, who murdered 4 individuals in London during 2014-2015, using GBMSM geosocial networking apps to arrange meetings and then concealing high doses of GHB in soft drinks to poison victims (26,29). Subsequent investigation around failings of the Metropolitan Police Service (MPS) to connect these murders and to suspicions of negligence due to systemic homophobia of the MPS led to increased attention on chemsex-related crimes (30). Political attention increased again in 2020 due to another high profile instance of chemsex-related crime involving a large number of sexual assaults and rapes involving GHB (31). This led to new police interest in the criminal justice elements of chemsex and led to the formation of Project Sagamore (32). In recent years, however, political attention on chemsex has waned; chemsex has not been mentioned as a focus of any major political party in the UK.

National policies



10-year drugs plan

The flagship document for the UK government's [10 year-drugs plan](#) was published in December 2022 (33). This plan set out an approach to “combat illegal drugs” by breaking drug supply chains, delivering a world class treatment & recovery system, and achieving a generational shift in the demand for drugs.

The plan focuses predominantly on reducing the use of heroin and crack cocaine. Chemsex is mentioned only twice. The first reference includes “GHB and other substances often involved in ‘chemsex’” in the list of drugs for which individuals will be supported into recovery. The second is a pledge to “support substance misuse commissioners and sexual health commissioners to work together to improve pathways between services for those who use drugs in a ‘chemsex’ context”. The first annual report for 2022–23 for the plan’s implementation, published in July 2023, contains no mention of chemsex (34).

Combating drugs partnerships (CDP)

The Central Government tasked local authorities to stand up CDPs to enact the plan laid out in the 10 year drugs strategy. In doing so, it provides [guidance](#) on how to implement the plan and monitor progress (35). There are no direct references to chemsex in this monitoring framework; however, it does include the recommendation that “partnerships merge funding streams where appropriate and engage in joint commissioning and service delivery—for example, as recommended by the Advisory Council on the Misuse of Drugs in relation to sexual health and substance misuse treatment services,” which points to intersecting goals of sexual health and substance use services to address chemsex needs and harms (35).

HIV action plan for England



HIV Action Plan for England,
2025 to 2030

Published 1 December 2025



Picture: Abigail Bruce, Hannah Nash and Eugene Lynch. Credits: Terence Higgins Trust, We Are Toucan and George House Trust.

The Department of Health and Social Care (DHSC) published its new [HIV Action Plan for England in 2025](#). The plan briefly notes that findings from a national survey of individuals living with HIV highlighted that chemsex can lead to sexual behaviour that may increase the risk of transmission of HIV (36).

In the action plan, DHSC recommends that Directors of Public Health (DPH) in all local authorities, along with other local and regional stakeholders, should improve links and care collaboration between sexual health, substance use services, and mental health services to better respond to the needs of people who engage in chemsex (37). This recommendation is categorised under the prevention priority of

the action plan.

Local policies

City & Hackney CDP

The [2019 DPH annual report](#), which focused on substance use in City and Hackney, and the [Joint Strategic Needs Assessment \(JSNA\) on substance use](#), which was published that same year,

recognised chemsex as an area requiring further consideration to understand the population level need and current trends (38,39).

The current strategic priorities developed by the City and Hackney CDP include specific aims to improve joint work and care coordination between sexual health services and substance use services for individuals engaged in chemsex, as well as to increase the offering of bespoke harm reduction support for individuals engaged in chemsex. As part of this, City and Hackney Public Health have established a multi-agency operational meeting in which professionals can refer cases of individuals engaged in chemsex with multiple support needs for triage and coordinated care. Altogether, this recent and increasing attention to comprehensively study and address the needs of those engaged in chemsex in City and Hackney and the relevant harms related to chemsex spurred this needs assessment.

City & Hackney sexual health strategy and action plan

City and Hackney Public Health recently produced a [sexual and reproductive health strategy](#) following a public consultation period (40). This strategy advocates for early and targeted support for chemsex to be available in sexual health services as a way to advance strategic priority 1: "healthy and fulfilling sexual relationships." Individuals who engage in chemsex are also listed as a specific priority group under strategic priority 5: "inclusion communities and those with complex needs."

To deliver this strategy, City and Hackney Public Health and partner services are working together to enhance the offering of harm reduction materials—such as needle and syringe provision, 'slamming packs', and bespoke information—available through sexual health services.

3. Methods

This needs assessment contains insights from three main elements.

Literature review

City and Hackney Public Health conducted an initial scoping search on PubMed using the search criteria of 'chemsex' in title, keyword and abstract over the past 5 years (Appendix 1). This returned 409 results. Staff then screened these citations for relevance and critically appraised them.

Public Health then conducted a further literature search with a focus on collating higher-level meta-analyses and systematic reviews. This included 8 databases with the search criteria of systematic reviews with 'chemsex' in title, keyword and abstract over the past 5 years. After deduplication, staff identified a total of 130 articles. Upon screening, a significant number of these articles were incorrectly labelled as systematic reviews but were kept as they still contained valuable insights. Public Health then combined insights from these systematic reviews and the scoping search with grey literature to form the evidence base cited throughout this needs assessment.

Quantitative research

Based on initial findings from the literature review about the general needs and harms associated with chemsex, Public Health developed a set of research questions to investigate the needs and harms of chemsex specific to City and Hackney. These were shared with stakeholders for feedback. In each case, questions were linked to the most appropriate known data source(s). Public Health then collected quantitative data through direct access or formal data requests to the appropriate associated organisations. There were limited data returns throughout the process. Data systems do not currently capture chemsex activity with a high degree of accuracy or precision.

Public Health developed proxy measures, using combinations of data fields recorded about individuals' sexual orientation, gender identity, and type of drug use, to isolate potential samples of individuals who engage in chemsex from the following databases (Table 3):

Table 3. Summary of datasets queried for quantitative research.

Genitourinary Medicine Clinic Activity Dataset (GUMCAD)*		
Purpose	Sample	Limitations

<p>The national dataset for surveillance of sexually transmitted infections (STIs)</p>	<p>This sample includes GBMSM, transgender women and transgender men, and nonbinary individuals (GBMSM+TGNC) who had consultations at Homerton Sexual Health Services (HSHS) where clinicians recorded use of methamphetamines, GHB/GBL, or mephedrone in a sexual context between 2023-2024.</p>	<p>More than 96% of consultations had incomplete data on drug or alcohol use; therefore, this dataset was not included in the analysis.</p>
--	---	---

National Drug Treatment Monitoring System (NDTMS)*

Purpose	Sample	Limitations
<p>The national dataset for local drug and alcohol treatment</p>	<p>This sample includes men who had recorded use of methamphetamine, GHB/GBL, or mephedrone in FY 2024-2025.</p>	<p>This sample only accounts for individuals in structured treatment. The drugs used by this sample may not be used in sexual contexts. This sample does not include transgender women or nonbinary individuals, due to lack of data fields on gender identity. This sample also includes men who may exclusively have sex with women, due to lack of completeness of data fields on sexual orientation. Given the high degree of uncertainty and limitations of this data, it is not included in the analysis.</p>

Sexual Health London (SHL)

Purpose	Sample	Limitations
<p>The local dataset that captures all orders for at-home testing kits for viral hepatitis and STIs in London.</p>	<p>This sample includes GBMSM+TGNC who ordered at-home STI testing kits between 2022-2024. The</p>	<p>This sample only accounts for individuals who have ordered tests through SHL. This sample may be subject to</p>

	original sample included multiple entries for individuals who ordered more than one testing kit between 2022-2024. To avoid double counting individuals who ordered multiple times, the most recent order was used for each individual. A sensitivity analysis was conducted to ensure this did not significantly bias the results. The details of this sensitivity analysis are in Appendix 2.	reporting bias. This sample may include individuals who use drugs other than chems or drink alcohol in sexual contexts, which is not considered chemsex.
--	---	--

***Note: Given the high degree of uncertainty and low data completeness, data from GUMCAD and NDTMS were excluded from data analysis.**

The following central databases have no data variables that could be used to isolate a proxy sample, rendering them unusable for the purposes of this needs assessment:

- Sexual and Reproductive Health Activity Dataset (SHRAD), the national dataset for NHS sexual and reproductive health services
- East London Database (ELD), the local database for primary care data
- London Ambulance Services (LAS), the local dataset on ambulance and paramedic engagement
- Hospital Episode Statistics (HES), the national dataset for information about admissions, outpatient appointments, and historical accident and emergency attendances at NHS hospitals in England
- SafeStats, the local dataset that compiles information on London crime and community safety from a variety of public agencies

Other quantitative data used in this needs assessment come from service user reports from the two main local services providing support for people engaged in chemsex. Therefore, they are only representative of the individuals engaging with services. Table 4 provides an overview of these data samples.

Table 4. Summary of local service datasets used for quantitative research.

Service	Number of service users	Proportion of individuals in sample from City and Hackney	Time frame
---------	-------------------------	---	------------

Antidote	35	100%	FY 2023/24
HSHS chemsex service	60	73%	FY 2024/25

These datasets also include additional uncertainties, which are discussed, that make it challenging to assert definitive findings on the needs and harms relating to chemsex in City and Hackney.

Qualitative research

Public Health conducted a series of semi-structured interviews to capture the experience of a range of professionals working across sectors on chemsex and supplement limited quantitative findings. Public Health interviewed a total of 18 professionals for approximately 1 hour each. These included representatives from a variety of organisations, such as the NHS, the United Kingdom Health Security Agency (UKHSA), VCS organisations providing specialised chemsex support, sexual assault referral centres (SARC), His Majesty's Prison and Probation Service (HMPPS) and the MPS. Discussion points included areas such as health needs, support services, system response, chemsex risks, harm reduction, and the criminal justice response. Public Health collated summarised notes from each of the interviews and analysed them using an inductive coding process to determine larger themes across all interviews. Given the uncertainties present in quantitative data, these themes were used to triangulate quantitative findings and provide additional insights into the local needs and harms associated with chemsex.

Limitations

Current data systems used in the UK to record and report health and social care events do not specifically define data as being related to chemsex or sexualised drug use. It is therefore difficult to construct precise samples of individuals who are practising chemsex or attribute health and social care events to chemsex activity. Furthermore, many data systems do not routinely capture information on gender identity, specifically on transgender identity, or sexual orientation; making it even more difficult to construct proxy samples of individuals who are in the LGBTQ+ community and may engage in sexualised drug use.

Based on feedback from professionals, City and Hackney Public Health decided that it was not appropriate to engage individuals who practice chemsex in qualitative research. This was primarily due to ethical concerns of disclosure of illicit activity and concerns that individuals who engage in chemsex would not be comfortable discussing their experiences with local authority officials. While this report incorporates qualitative findings from research with local professionals, as well as published qualitative research with people who engage in chemsex, the lack of insight from local individuals who engage in chemsex is a limitation. Future local needs

assessments should attempt to engage individuals through trusted community organisations with appropriate ethical oversight.

4. Findings

4.1 Prevalence and demographics

General findings

It is challenging to quantify the prevalence of GBMSM who participate in chemsex. Prevalence estimates from global literature vary depending on a number of factors, including: how chemsex is defined (which drugs, which communities, which practises), how people are asked about their practice, what people are asked, what communities are asked, and the context of the study.

A recent cross-sectional study using data from an online community survey of over 2750 GBMSM+TGNC in the UK found that approximately 8% of respondents reported using chems in the last year and 15% reported ever using chems (41). The vast majority of respondents reporting recent chems use (90%) specified that use was in a sexual context. Respondents reporting chems use were more likely to be gay and living in London.

Further quantitative evidence of chemsex prevalence in GBMSM comes from two systematic reviews—one reviewing studies in North America, Europe, and Australia, and one reviewing studies from Europe (2,5). In both studies, researchers identified estimates of chemsex prevalence to be between 10-20% amongst GBMSM. These studies found that the most commonly identified demographics of chemsex participants to be white, cisgender men aged 30-45 (2,5). The studies examined in these reviews are open to selection bias, however, as they primarily sampled from GBMSM presenting at sexual health clinics or online dating apps, which only represents a subgroup of GBMSM. As a result, this may result in an underestimate of the true prevalence of chemsex participation amongst GBMSM and under-representation of minority groups and individuals aged outside of the 30-45 age range, who may be less likely to engage with sexual health services and online apps.

Local findings

Local data on the profile of people engaging in chemsex in City and Hackney do not exist outside of the recorded demographic data for people engaged with services that provide support for chemsex and data on GBMSM+TGNC who ordered at-home tests from SHL for HIV, STIs, and viral hepatitis. Given data limitations, it is not possible to estimate descriptive statistics of the true demographic profile of GBMSM+TGNC in City and Hackney who engage in chemsex, overall; however, data from local support providers and SHL show similarities between the local demographic profile and that seen in the literature (2,3,5).

Prevalence

There are no specific prevalence figures for chemsex activity in City and Hackney. Data from services that support people who engage in chemsex cannot provide an accurate estimate of the overall prevalence of people who engage in chemsex, as they likely represent a small subsample of people who engage in chemsex. However, combining 2021 Census data from the Office of National Statistics (ONS) on the numbers of GBMSM living in City and Hackney with the estimated range of point-in-time chemsex activity prevalence amongst GBMSM from the two systematic reviews, it can be estimated that between **845 and 1,691 GBMSM in Hackney and 44 and 88 GBMSM in the City of London** may be actively engaged in chemsex at any given time (Tables 5 & 6) (2.5.42).

Table 5. Estimated prevalence of chemsex in Hackney.

Age	Male population	Proportion who identify as LGBTQ+	GBMSM+TGNC population estimate	% of total GBMSM+TGNC population estimate	Estimate of chemsex engagement amongst GBMSM+TGNC	
					10%	20%
16-24	14233	5.8%	830	10%	83	166
25-34	29582	11.9%	3526	42%	353	705
35-49	27723	9.7%	2697	32%	270	539
50-64	18021	6.5%	1164	14%	116	233
65+	9123	2.6%	235	3%	24	47
Total	98682	8.6%	8453	100%	845	1691

Source: ONS. Sexual orientation, England and Wales: Census 2021. 2023.

Notes: Age brackets 35-49, 50-64, and 65+ did not match between male population data and GBMSM prevalence data. Therefore, weighted averages were calculated to estimate the prevalence of GBMSM within these age ranges.

Table 6. Estimated prevalence of chemsex in the City of London.

Total	Male population	Proportion who identify as LGBTQ+	GBMSM+TGNC population estimate	% of total GBMSM+TGNC population estimate	Estimate of chemsex engagement amongst GBMSM+TGNC	
					10%	20%
	4425	9.9%	438	100%	44	88

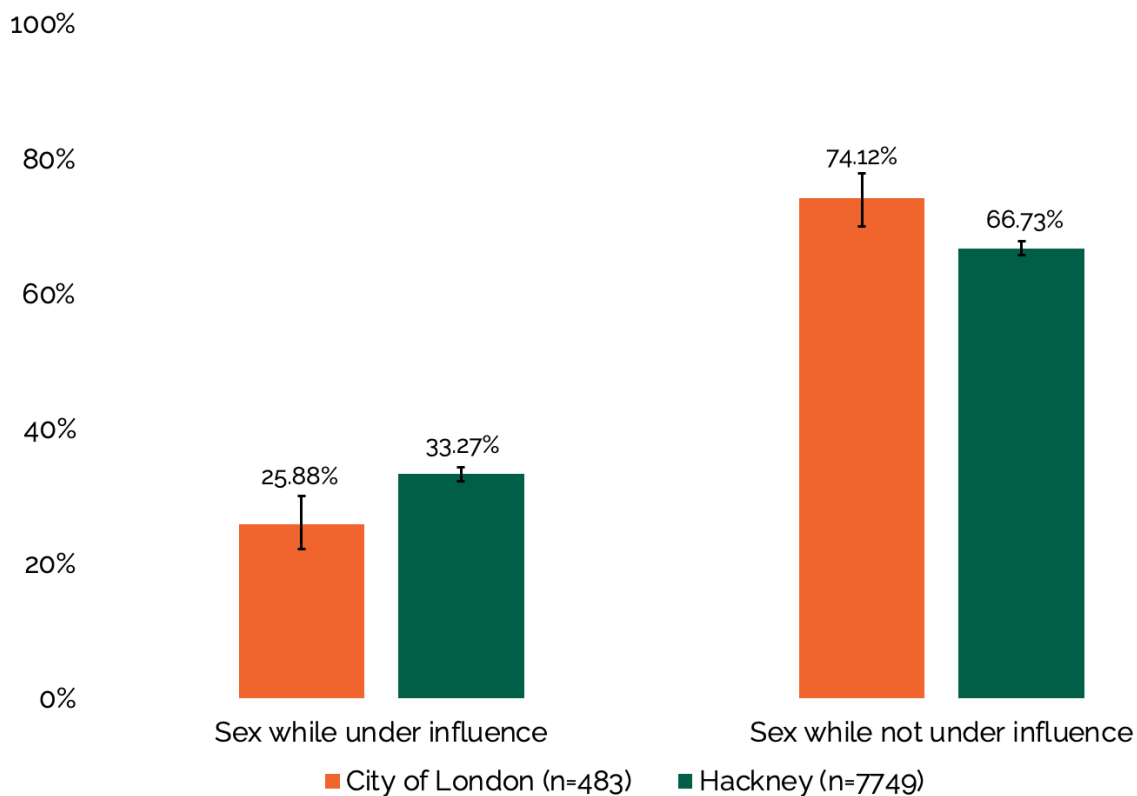
Source: ONS. Sexual orientation, England and Wales: Census 2021. 2023.

Notes: Breakdown of prevalence of GBMSM not available by age.

Importantly, these prevalence estimates draw from studies across North America, Europe, and Australia, and since engagement in chemsex is highly dependent on local social environments, they must be viewed with caution. However, until more accurate quantitative data are available on chemsex participation in City and Hackney, this is the best working prevalence estimate achievable.

Data from SHL of GBMSM+TGNC service users from City and Hackney between 2022-2024 furthers these estimates (43). In assessing the most recent SHL order for each unique service user (see Appendix 2), 25.88% (CI: 22.18%-29.97%) of the 483 GBMSM+TGNC service users in the City of London reported using drugs or alcohol before or during sex at least in that three-year time period. This proportion was slightly higher amongst GBMSM+TGNC in Hackney, with 33.27% (CI: 32.23%-34.33%) of GBMSM+TGNC service users who reported having sex while under the influence at least once in their most recent testing year between 2022-2024 (Figure 2).

Figure 2. GBMSM+TGNC SHL service users from City and Hackney by reported engagement in sex while under the influence in their most recent testing year, 2022-2024.

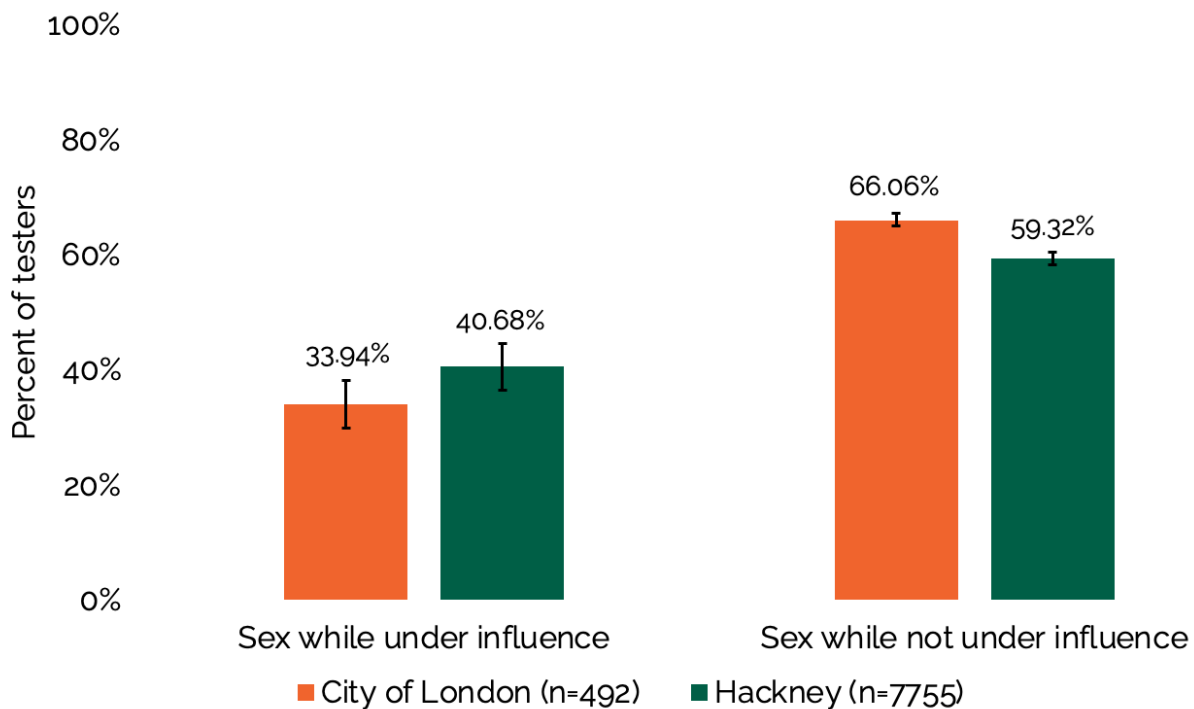


Source: Preventx. SHL service users from City of London and Hackney, 2022-2024. 2025.

The prevalence of chemsex activity increases when assessing how many unique GBMSM+TGNC SHL service users ever reported having sex while under the influence of drugs or alcohol during the three year period, not just in their most recent testing year. Amongst the 492 unique service

users in the City, 33.94% (CI: 29.90%-38.24%) ever reported sex while under the influence of and amongst the 7,755 unique service users in Hackney, 40.68% (CI: 39.59%-41.78%) (Figure 3).

Figure 3. GBMSM+TGNC SHL service users from City and Hackney by ever reported engagement in sex while under the influence, 2022-2024.



Source: Preventx. SHL service users from City of London and Hackney, 2022-2024. 2025.

Note: There were 15 service users who lived in both the City and Hackney between 2022-2024 so they are counted in both geographic areas to determine prevalence in Figure 3. This is why the sample sizes for each local authority are different in Figures 2 and 3.

Given data limitations, these proportions cannot be taken as an accurate estimate of the prevalence of chemsex participation in Hackney or the City. Individuals who report having sex under the influence of drugs may not be engaged in chemsex as defined by this needs assessment—individuals may be using substances other than those involved in chemsex (eg., alcohol, cannabis, MDMA) or may not be intentionally combining drugs for the purpose of sex. Furthermore, individuals may engage in chemsex once or only for a short time period during the year; meaning that the true point-in-time prevalence of chemsex is likely lower than these numbers suggest.

Interviewed professionals believe that engagement in chemsex is increasing amongst GBMSM, and in particular, use of methamphetamines and GHB/GBL (4). Professionals also expressed that use of mephedrone for chemsex is declining, however mephedrone is increasingly being used outside of sexual contexts in nightlife and concerts/festivals. A minority of professionals interviewed believe that overall prevalence of chemsex activity has remained relatively stable, but that general awareness of chemsex and services has increased and so the perception is that prevalence has also increased.

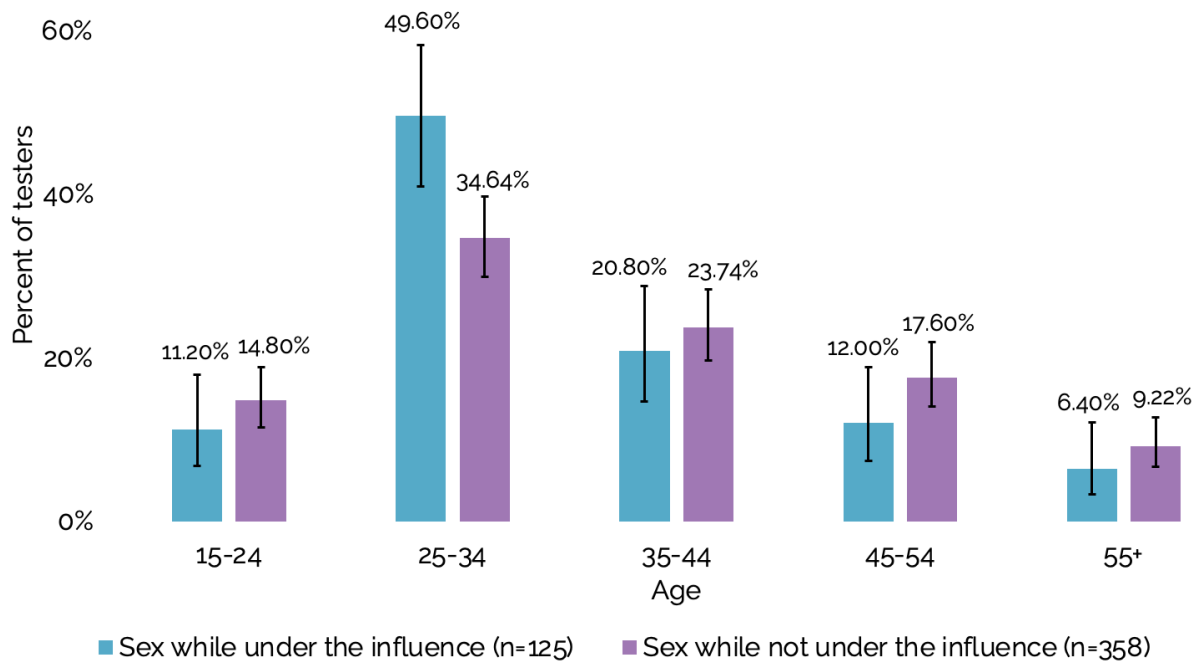
Given the constraints and limitations of available data, the following sections report the general demographic profile of individuals who may be engaged in chemsex in City and Hackney based on data from local services and from SHL. Estimates from SHL data use information provided by the service users in their most recent testing year to determine user characteristics in order to avoid double counting users who ordered multiple times between 2022-2024. See Appendix 2 for more information on this sampling method.

Age

Local data seems to support the findings of literature. The majority of service users engaged in support services at Antidote or the HSHS chemsex service fall within the 26-45 age range (44,45). These proportions also align with the age breakdown of GBMSM in Hackney overall, according to 2021 Census data (46). Data on the age breakdown of GBMSM is not available for the City.

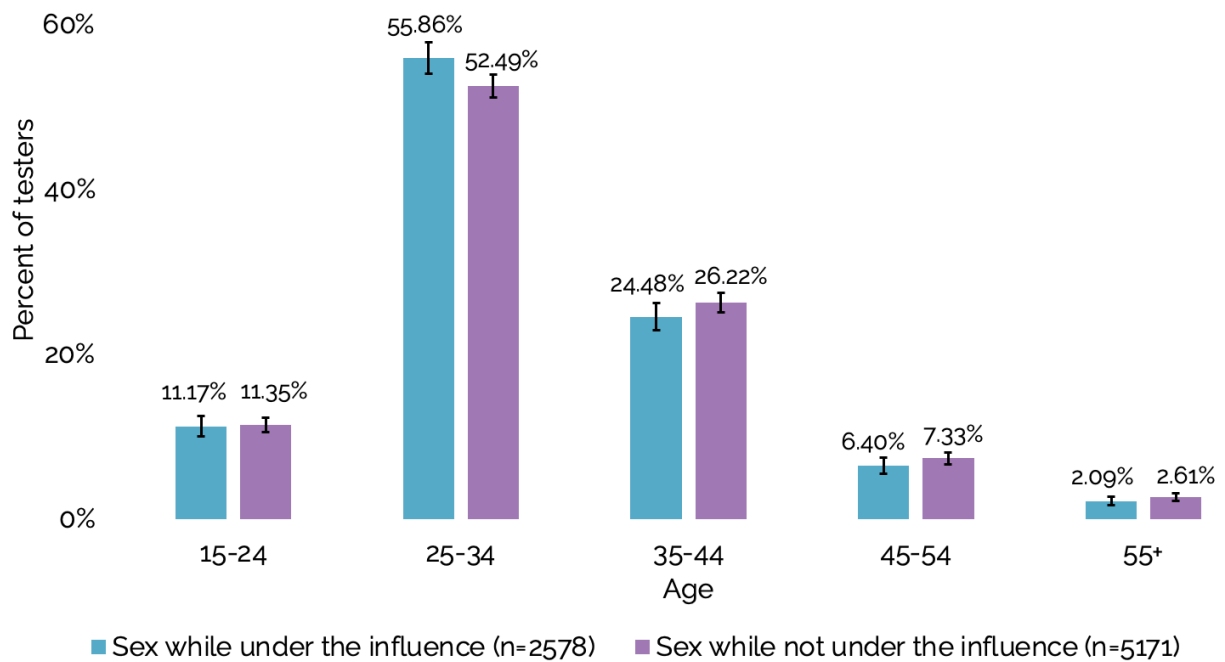
Similarly, data from SHL on the age range of GBMSM+TGNC service users who ordered at-home STI and viral hepatitis testing kits in City and Hackney between 2022-2024 shows that most GBMSM+TGNC who reported sex while under the influence of substances in their most recent testing year, were between 25 and 44 years old (Figures 4 & 5) (43). While there were slight differences in the relative proportions of GBMSM+TGNC across different age groups between GBMSM+TGNC who reported having sex under the influence in their recent testing year compared to those who did not, these differences were not statistically significant.

Figure 4. GBMSM+TGNC SHL service users from the City by age and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from the City of London, 2022-2024. 2025.

Figure 5. GBMSM+TGNC SHL service users from Hackney by age and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



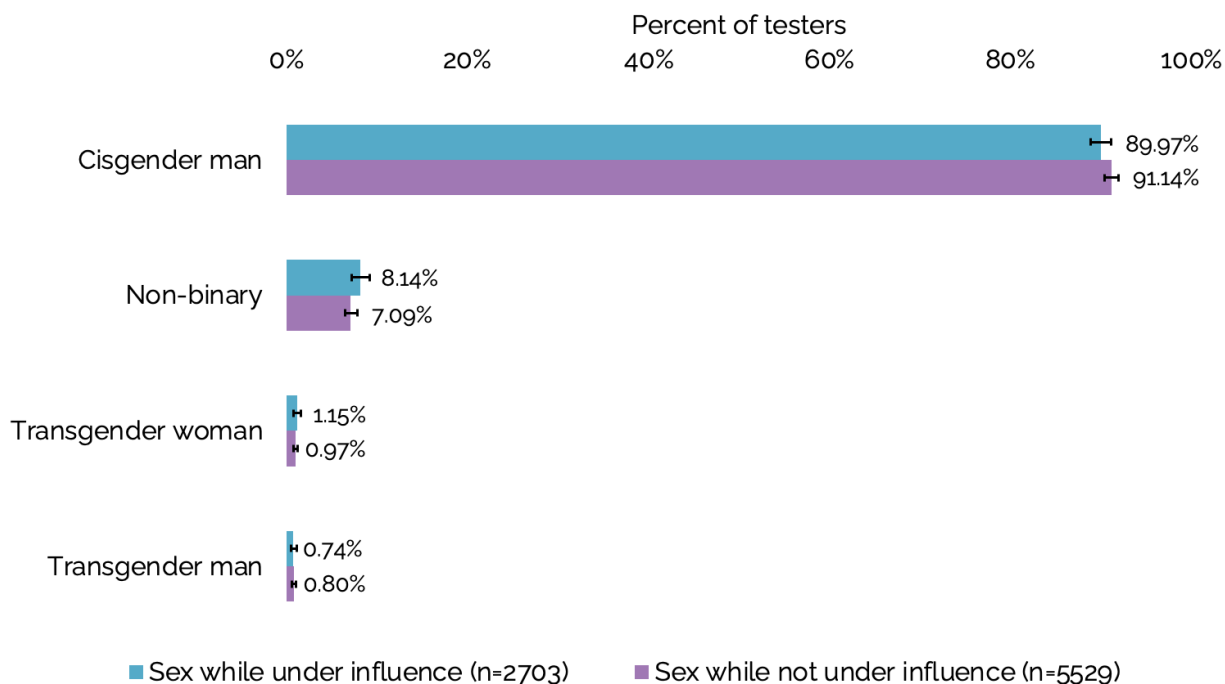
Source: Preventx. SHL users from Hackney, 2022-2024. 2025.

Gender

Data from Antidote service users from City and Hackney in FY 23/24 showed that the majority of service users identified as cisgender men (86%); however, numbers in service for other genders are too small to show.

This is similar to proportions seen in SHL data, with close to 90% (CI: 88.78%-91.05%) of GBMSM+TGNC who report having sex under the influence of drugs or alcohol in their most recent testing year identifying as a cisgender man. The relative gender breakdown of individuals reporting sex while under the influence in their most recent testing year is similar to that of individuals who do not report sex while under the influence (Figure 6).

Figure 6. GBMSM+TGNC SHL service users from City and Hackney by gender and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from City of London and Hackney, 2022-2024. 2025.

Note: Samples from City and Hackney are combined due to small numbers in some groups.

Interviewees noted that the narrow definition of chemsex and its historical ties to white cisgender gay men may feel restrictive and potentially marginalise other LGBTQ+ individuals, such as trans and non-binary individuals, who engage in similar types of SDU, from engaging with support services (4). Furthermore, while TGNC individuals may be engaged in chemsex and SDU at the same rates as GBMSM, they make up a smaller proportion of the overall population of GBMSM+TGNC and so will likely account for a smaller proportion of the population of individuals who engage in chemsex.

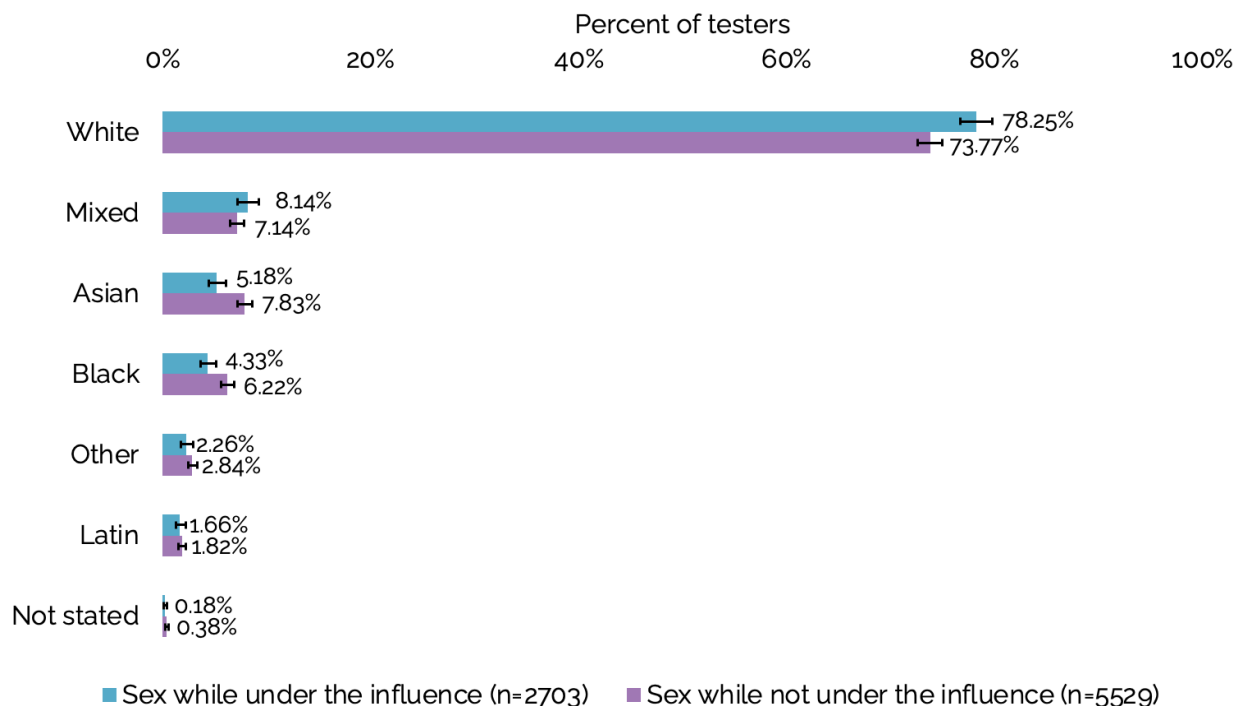
Ethnicity

There are no data on the breakdown of GBMSM, overall, in City and Hackney across different ethnic groups; therefore, it is difficult to determine potential differences in the ethnic profile of GBMSM engaged in chemsex. However, compared to the general population of City and Hackney, white GBMSM are overrepresented in local chemsex support services delivered by Antidote and HSHS, whereas Asian and Black GBMSM are underrepresented (44,45). Data from services cannot be displayed due to the small sample sizes.

Data from SHL also reflect this disproportionate representation of white individuals, with 78.25% (CI: 76.65%-79.76%) of GBMSM+TGNC who report sex while under the influence of drugs or alcohol in their most recent testing year identifying as white (Figure 7). The proportions of

GBMSM+TGNC who report sex while under the influence who identify as Asian or Black are slightly lower than the proportions of GBMSM+TGNC who never report sex while under the influence who identify as either of those groups, but these differences are not statistically significant.

Figure 7. GBMSM+TGNC SHL service users from the City by ethnic group and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from City of London and Hackney, 2022-2024. 2025.

Note: Samples from City and Hackney are combined due to small numbers in some groups.

It is important to note that ethnic demographic categories are defined in different ways by different services and thus are open to variation and misclassification. The method used to aggregate SHL ethnicity data into ethnic groups is detailed in Appendix 3.

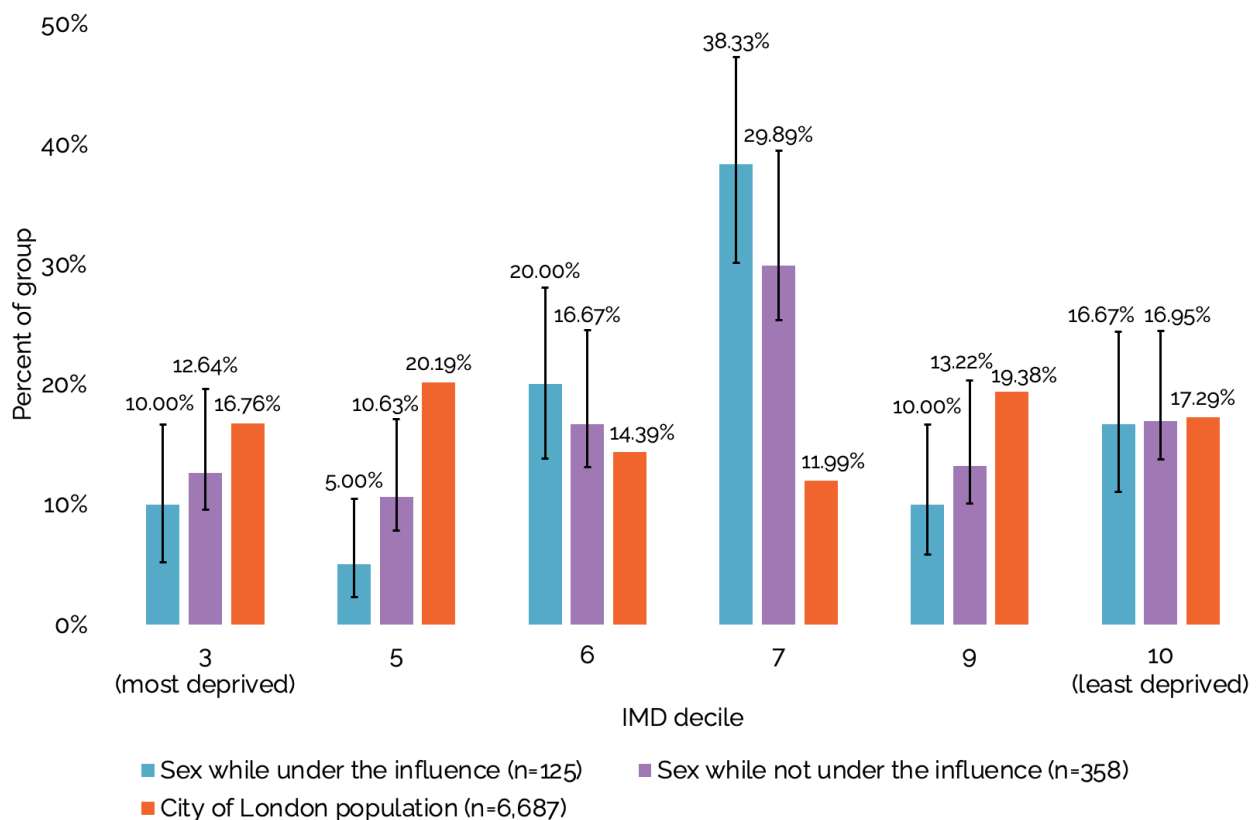
Underrepresentation of black and global majority ethnic groups in both SHL data and chemsex support services may be because white GBMSM+TGNC in City and Hackney are more likely to engage in chemsex, but also may be because they are more likely than others to test with SHL and engage with support services for chemsex, while Asian and Black GBMSM+TGNC are less likely to engage with services. As interviewed professionals noted, part of the reason for this is that 'chemsex' is seen by many of these communities as a term that reflects white, cisgender men (4). As such, GBMSM+TGNC from global majority ethnic groups in City and Hackney who may engage in chemsex may perceive services that advertise themselves as chemsex support as inaccessible. Furthermore, professionals noted that intersectional stigma experienced by

LGBTQ+ people from black and global ethnic backgrounds may serve as a further barrier to seeking out and accessing support.

Deprivation

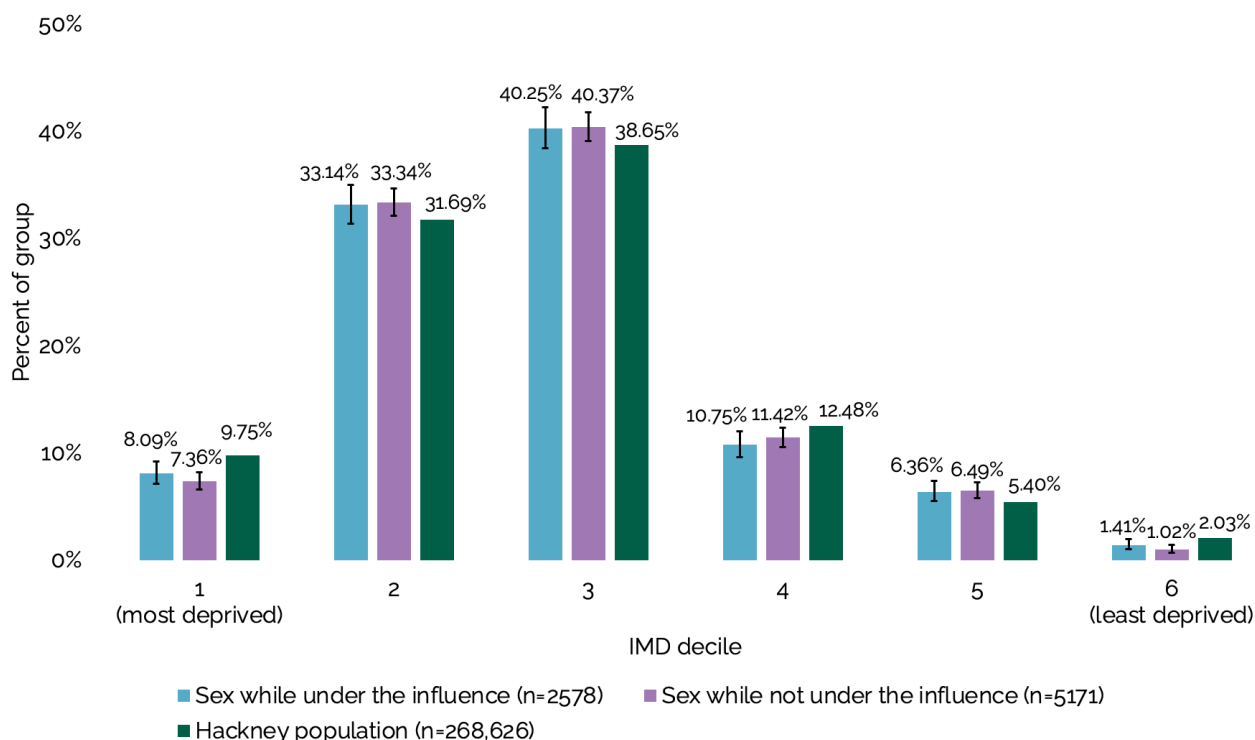
SHL data includes information on the level of deprivation of the Lower Super Output Area (LSOA) in which individuals ordering tests reside, as classified by the 2019 Index of Multiple Deprivation (IMD) (47). Importantly, this index does not necessarily correspond to the specific level of deprivation of the individual who ordered the test, but rather, the LSOA in which they live. There were no significant differences between the level of deprivation of GBMSM+TGNC who report sex while under the influence of drugs or alcohol in their most recent testing year, GBMSM+TGNC who do not report sex while under the influence, and the general population in both the City of London and Hackney (Figures 8 & 9).

Figure 8. GBMSM+TGNC SHL service users from the City by IMD decile and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Sources: Preventx. SHL users from the City of London, 2022-2024. 2025; [GOV.UK](https://www.gov.uk), English indices of deprivation 2019, 2019.

Figure 9. GBMSM+TGNC SHL service users from Hackney by IMD and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



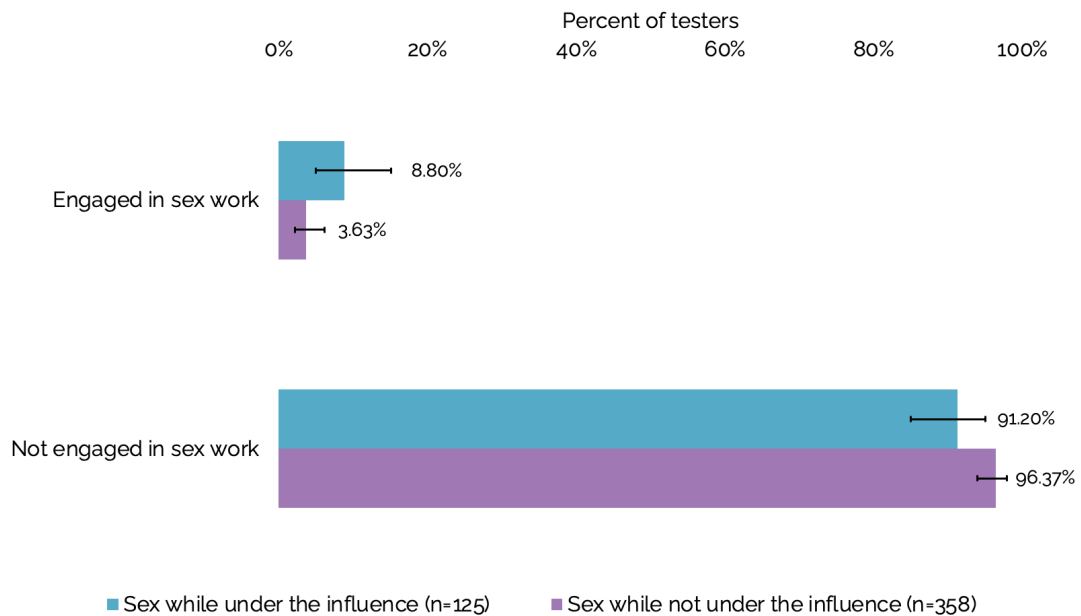
Sources: Preventx. SHL users from Hackney, 2022-2024. 2025; [GOV.UK](https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019), English indices of deprivation 2019, 2019.

Other demographic information

Some services provided additional demographic information on service users. Amongst the 35 service users from City and Hackney receiving support from Antidote, the majority identified as Christian (45). The same Antidote report also provides the only current local information on employment and housing status of service users, which shows the majority are in regular employment (57%) or unemployed and seeking work (26%), and either privately rent (51.43%) or own their own property.

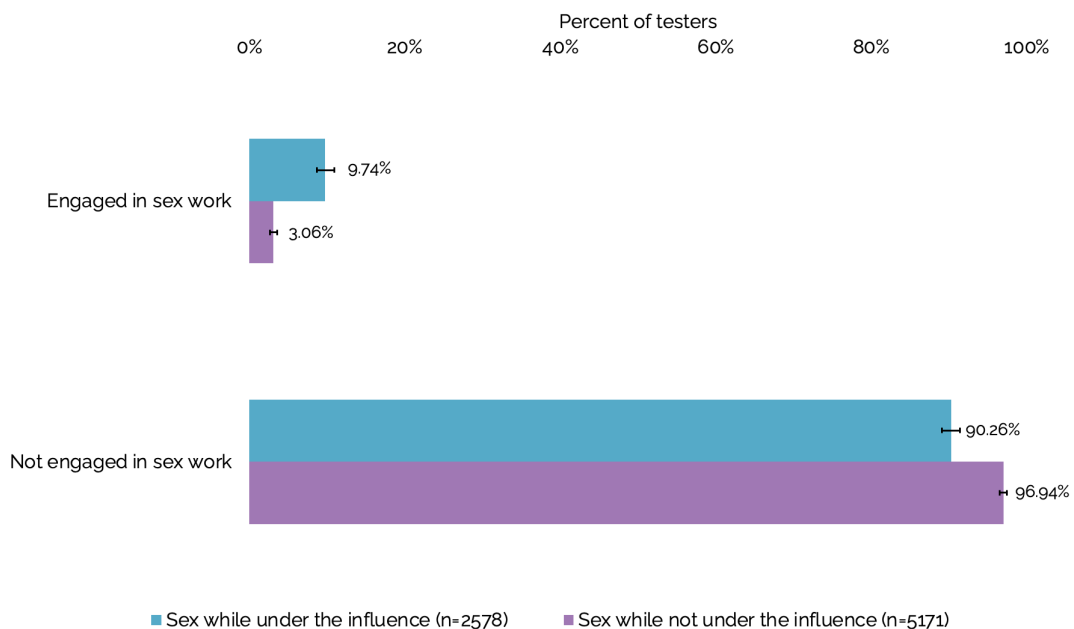
Finally, 20% of Antidote service users from City and Hackney in FY 23/24 also reported history of engagement in sex work, with a small minority reporting continued engagement in sex work (45). This is slightly lower than the proportion of GBMSM+TGNC who report having sex while under the influence of drugs or alcohol in their most recent testing year and also report sex work in the same year based on SHL data from both City and Hackney (Figures 10 & 11).

Figure 10. GBMSM+TGNC SHL service users from the City by reported engagement in sex work and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from the City of London, 2022-2024. 2025.

Figure 11. GBMSM+TGNC SHL service users from Hackney by reported engagement in sex work and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL at-home testing kits from Hackney, 2022-2024. 2025.

In the City, GBMSM+TGNC who reported sex while under the influence had a 2.56 greater odds (CI: 1.12-5.87) of also reporting engagement in sex work in the same year compared to GBMSM+TGNC who did not report having sex while under the influence. These odds were greater in Hackney, with GBMSM+TGNC who reported sex while under the influence having a 3.42 greater odds (CI: 2.79-4.20) of also reporting engagement in sex work in the same year compared to GBMSM+TGNC who did not report having sex while under the influence.

These increased odds echo the perceptions of interviewed professionals, who noted that, while still a minority, it is more common for individuals in the chemsex scene to engage in sex work, either as part of their chemsex practice or outside it (4).

4.2 Practices

General findings

While historic definitions of chemsex involved only the use of methamphetamines, GHB/GBL, and/or mephedrone, recent systematic reviews have found that GBMSM+TGNC are increasingly using other drugs, especially ketamine, in combination with traditional chemsex drugs, or on their own in settings that mirror chemsex (2,3,5,6,10,48). Exact prevalence of the use of each drug amongst people who engage in chemsex varies by geographic and social contexts. Some social networks favour use of certain chems over others based on previous experience and desired effects of use. For example, use of ketamine in chemsex contexts may be favoured by transgender individuals because the dissociative effects of ketamine help to dampen feelings of gender dysphoria in sexual contexts (41). Use of certain drugs may also fluctuate based on changes in drug availability in the local drug market (4).

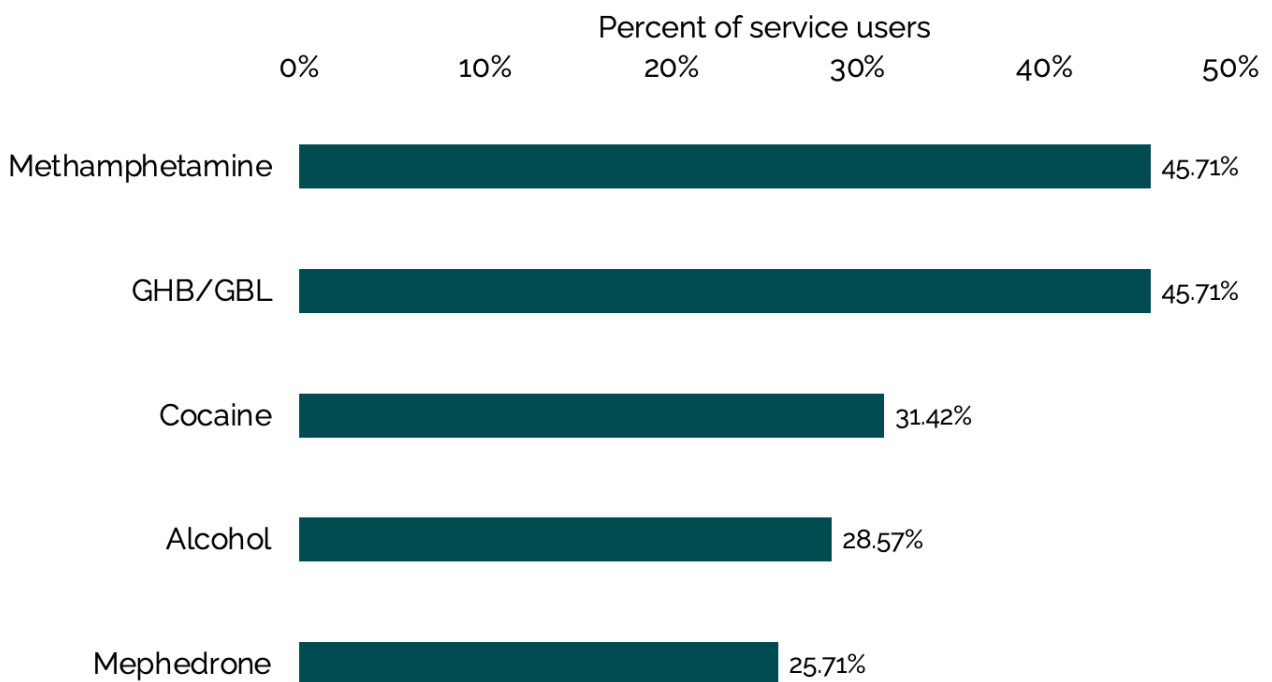
Chemsex occurs in many settings, ranging from informal 'chillouts' between partners or amongst groups of close friends to highly structured, planned sessions either between individuals or in a group (49). These sessions are generally organised through geosocial networking apps like Grindr and Scruff and participants may not know each other beforehand (2,6,14). The same apps and advertisements are also used to distribute chems themselves and function as part of the drug supply network. Drugs are taken before and during sexual activity and can be smoked, snorted, orally ingested, or absorbed through insertion into the rectum (known as 'boofing' or 'booty bumping'). Recent reviews, including a 2024 online survey of GBMSM+TGNC in the UK, estimate that between 10-30% of people who practice chemsex may inject or "slam" chems, usually methamphetamines or mephedrone (2,5,7,41). Engagement can range from infrequent, controlled experiences through to cycles of frequent multi-day sessions.

Local findings

Types of drugs used

The small amount of data available about the types of substances used in chemsex comes from the client profiles of 35 Antidote service users from City and Hackney (45). The most commonly used substance of the main three substances associated with chemsex was methamphetamine followed by GHB/GBL (Figure 12). Mephedrone was less commonly used by service users. A minority of service users also sought support for ketamine, MDMA, and cannabis.

Figure 12. Proportion of substances used by Antidote service users from City and Hackney (n=35). FY 23/24.

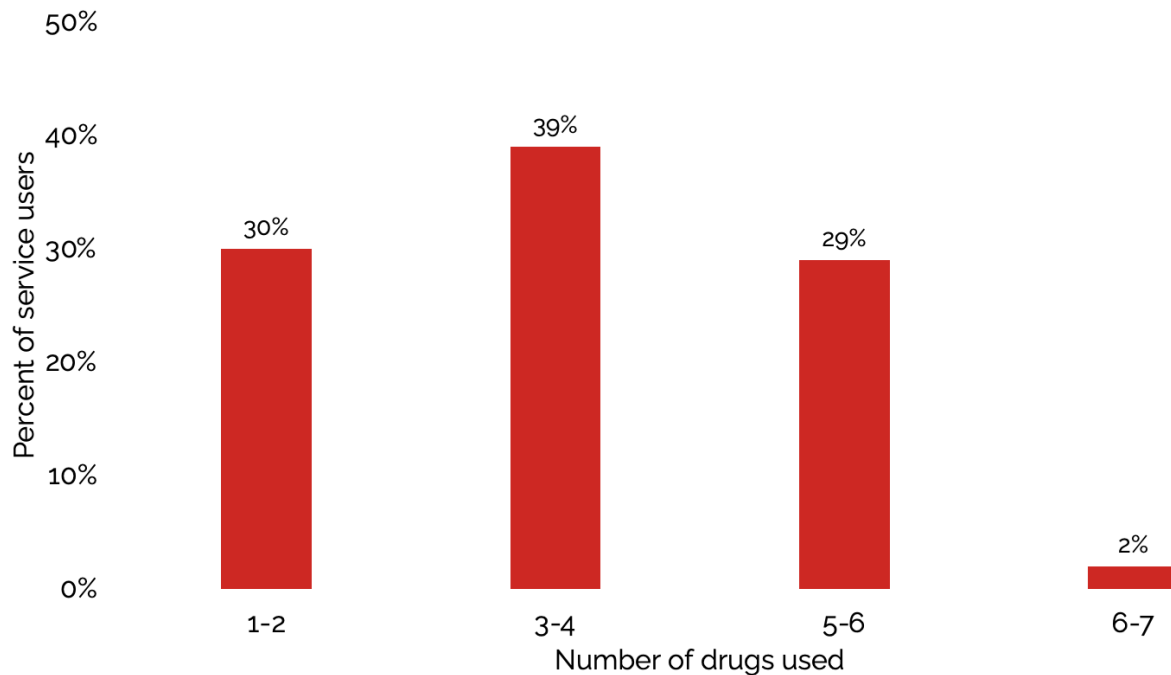


Source: Moncrieff, M. Antidote service user report: Hackney and the City of London (23/24). 2024.

Note: Individuals may report using more than one substance, so the sum of all columns will not equal 100%.

Data from the HSHS chemsex service shows that poly drug use is common amongst those referred for support, with the majority of individuals reporting using three or more substances (Figure 13) (44).

Figure 13. Number of substances used by individuals referred for support to the HSHS chemsex service (n=60), FY 24/25.



Source: Revez, A. et al. High risk sex and chemsex service annual report: 2024-2025. 2025.

Interviewed professionals explained that it is common amongst people who frequently engage in chemsex to combine methamphetamines and GHB/GBL, as the two are seen to counteract each other; when individuals are feeling drowsy and disoriented from potential GHB overdose, they will take methamphetamines and when they are feeling overly alert and 'wired', they will take GHB (4). This mirrors findings from a recent review, which found that GBMSM express using methamphetamines as a pseudo antidote to GHB/GBL overdose (11). However, combined use of these drugs may mask the effects of each drug per dose and therefore lead to greater risk of overdose, along with the risk of pharmacological interaction between potential unknown adulterants (50).

In addition to these three drugs, both Antidote and HSHS also report high use of cocaine and ketamine amongst their client populations. While not traditionally associated with chemsex, interviewed professionals note that use of other drugs like these in chemsex contexts is also common, which speaks to the need to re-evaluate traditionally narrow definitions of what constitutes chemsex (4).

Frequency of engagement

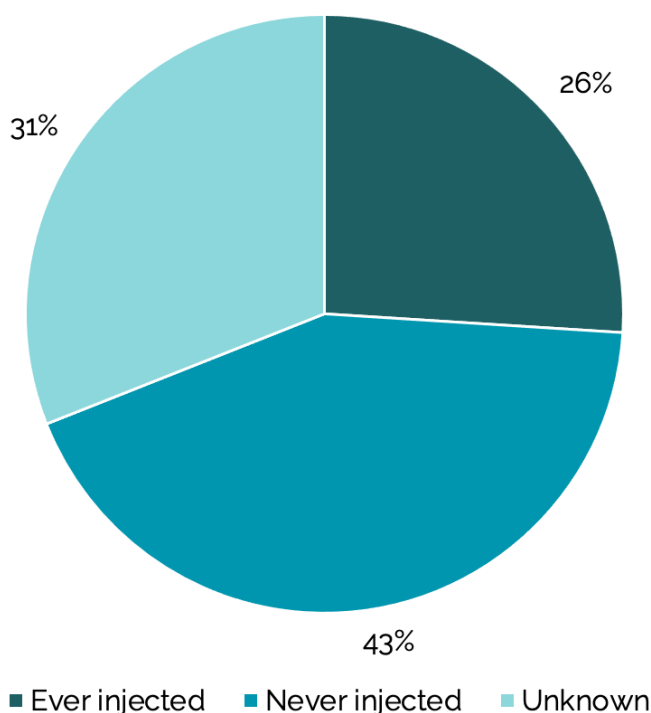
There is no local data available on the frequency with which people engage in chemsex.

Interviewed professionals expressed that there is wide variation in the frequency with which people engage in chemsex (4). The majority of individuals may engage in chemsex sessions once or twice a month on weekends and have relative control and stability in their engagement. Some interviewees however described that a subset of individuals may engage in chemsex every weekend, often for multiple days on end. This can be by choice but may also indicate underlying dependence. Interviewees also shared that individuals who engage in chemsex frequently can become at risk of dependence on the drugs themselves and may continue to use chems daily outside of sexual contexts.

Injection drug use

Data from 35 City and Hackney residents receiving support from Antidote show that 43% of individuals had never injected drugs as part of chemsex, while just over a quarter had ever injected drugs (Figure 14) (45). A small minority of these individuals reported current injection drug use.

Figure 14. Injecting status of Antidote service users from City and Hackney (n=35), FY 23/24.

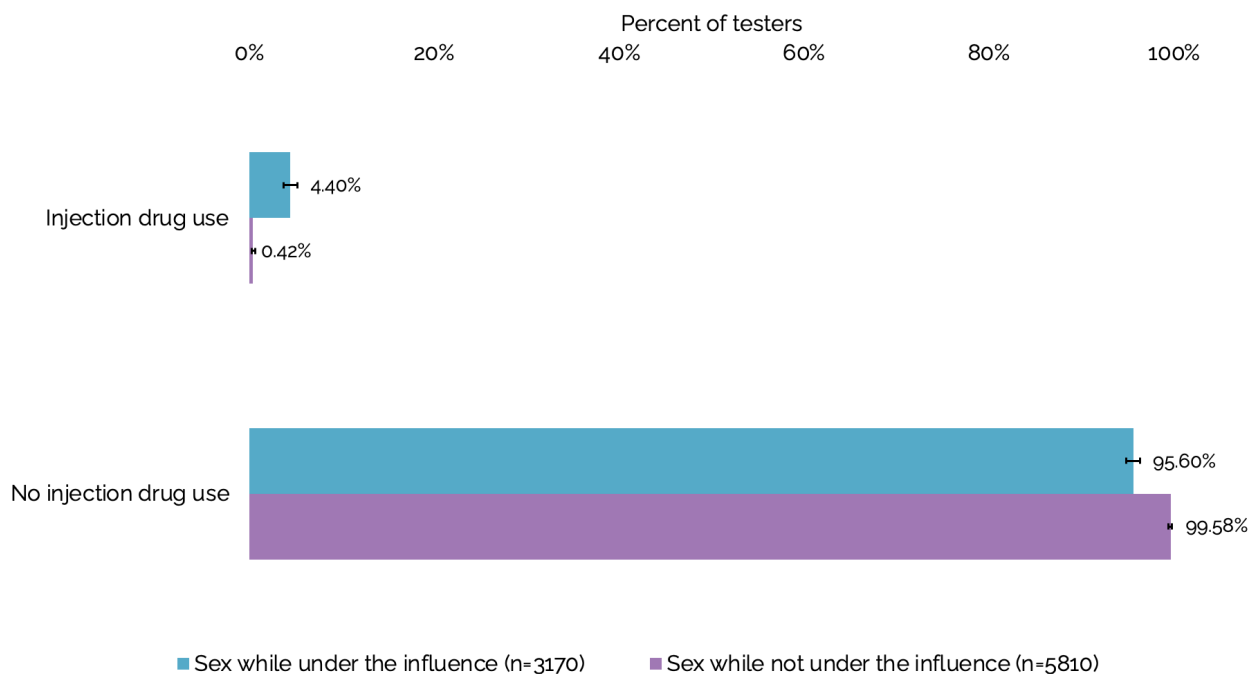


Source: Moncrieff, M. Antidote service user report: Hackney and the City of London (23/24). 2024.

The proportion of injection drug use reported amongst Antidote service users is much greater than the proportion of GBMSM+TGNC SHL service users from City and Hackney who report injecting drugs and having sex while under the influence of drugs or alcohol in the same year based on their most recent testing year (4.72%, CI: 3.69%-5.24%) (Figure 15). However, this

difference may be attributable to the relatively small sample size of Antidote data compared to SHL data.

Figure 15. GBMSM+TGNC SHL service users from City and Hackney by reported injection drug use and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from the City of London and Hackney, 2022-2024. 2025.

Note: Samples from City and Hackney are combined due to small numbers in some groups.

GBMSM+TGNC in City and Hackney who report sex while under the influence in any given year have 11.02 greater odds of also reporting injecting drugs in the same year (CI: 7.04-17.27), showing that injection drug use amongst GBMSM+TGNC is strongly associated with, though not necessarily related to, engaging sex while under the influence of drugs or alcohol.

Interviewed professionals noted that, while injecting chemsex drugs is not uncommon, it is often seen amongst GBMSM who engage in chemsex as a subculture within chemsex practice (4). GBMSM who inject drugs as part of chemsex can face stigma from other GBMSM who engage in chemsex by taking drugs through other routes of administration and is often seen as indicative of dependence on chems. This may be another reason why individuals who report injection drug use may be disproportionately represented in support services, like Antidote.

Multiplying the estimated number of GBMSM+TGNC in City and Hackney (Tables 5 & 6) by the proportion of GBMSM+TGNC who report having sex while under the influence of drugs or alcohol and the proportion who report injection drug use, it can be estimated that roughly 150 GBMSM+TGNC in City and Hackney may currently or have previously injected chems. Due to the

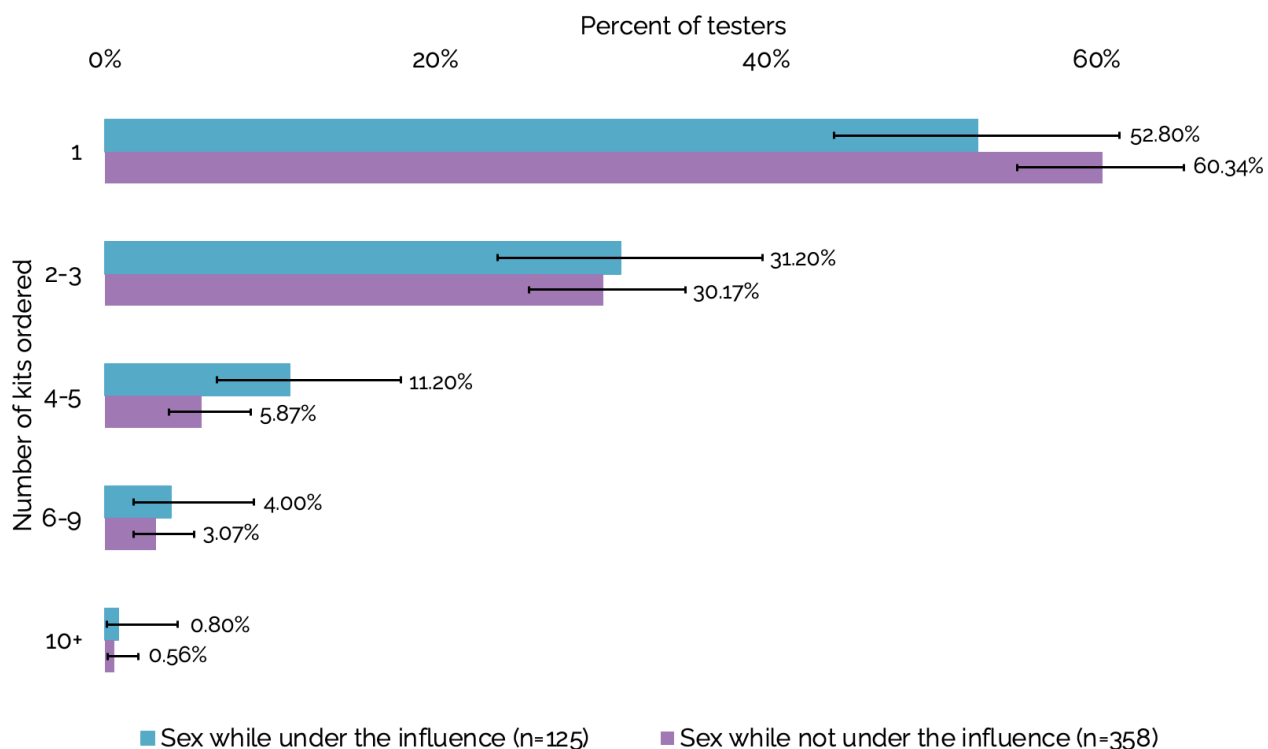
uncertainties and limitations in these data, this is only a crude approximation and must be used with caution.

Sexual activity

Again, the available data for analysis on the sexual practices of GBMSM who engage in chemsex is very limited. Data from the Antidote service user report showed that most service users reported an average number of sexual partners per session of between 1 and 5. Many service users (40%) reported never using condoms during chemsex sessions; however, 75% of service users who were HIV-negative reported that they are highly adherent to HIV preexposure prophylaxis (PrEP), an effective HIV prevention medication (45). The sample is too small to show data in this report.

Data from SHL show that the total number of test kits ordered per individual in City or Hackney between 2022-2024 did not differ significantly between GBMSM+TGNC who reported having sex while under the influence of drugs or alcohol in their most recent testing year and GBMSM+TGNC who did not report sex while under the influence (Figures 16 & 17).

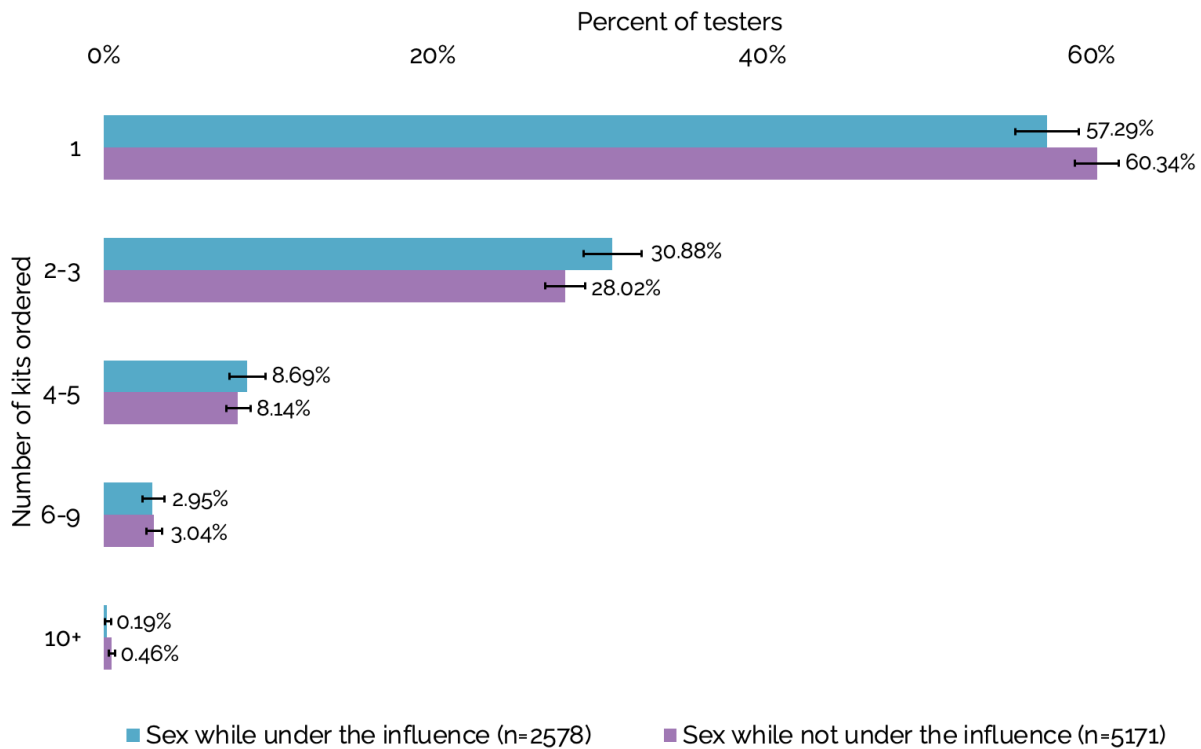
Figure 16. GBMSM+TGNC SHL service users from the City by total number of test kits ordered and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL users from the City of London, 2022-2024. 2025

The average number of test kits ordered by GBMSM+TGNC from the City between 2022-2024 who reported having sex while under the influence in their most recent testing year was 4.14. The average number of test kits ordered by GBMSM+TGNC from the City who did not report having sex while under the influence was 3.49; however, this difference was not statistically significant.

Figure 17. GBMSM+TGNC SHL service users from Hackney by total number of test kits ordered and reported engagement in sex while under the influence in their most recent testing year, 2022-2024.



Source: Preventx. SHL at-home testing kits from Hackney, 2022-2024. 2025

There was less of a difference between groups in Hackney. The average number of test kits ordered by GBMSM+TGNC from Hackney between 2022-2024 who reported having sex while under the influence in their most recent testing year was 3.55. The average number of test kits ordered by GBMSM+TGNC from the City who did not report having sex while under the influence was 3.52. Again, this difference was not statistically significant. All together, this means that GBMSM+TGNC individuals in City and Hackney who have sex while under the influence of drugs or alcohol do not necessarily test for STIs more than GBMSM+TGNC in City and Hackney who do not have sex while under the influence of sex or alcohol.

4.3 Health risks and harms

General findings

Drug-related harms

It is important to note that use of chems does not inherently or automatically result in harms; however, while individuals experience positive effects from their use of chems—such as decreased inhibitions, increased energy and intimacy, and increased sexual performance—chems can also carry many short-term and long-term harmful side effects (Table 7) (51–58). Furthermore, since all three major chems are illegal in the UK, they are not subject to regulation for purity or potency and have the potential to contain harmful adulterants, leading to further unpredictable side effects and harms.

Table 7. Harmful effects of chems.

Methamphetamine	GHB/GBL*	Mephedrone
Short Term Harmful Effects		
Tachycardia, arrhythmia, hypertension, tachypnoea, hyperthermia, insomnia, anxiety, paranoia, aggression and violence, stroke, myocardial infarction, tremors, convulsions, seizures, psychosis, overdose and death.	Drowsiness, nausea and vomiting, diarrhoea, bradycardia, hypothermia, hypotension, ataxia, diplopia, dysarthria, seizures, loss of consciousness and coma, respiratory depression, psychosis, neurotoxicity, overdose and death.	Bruxism, diplopia, mydriasis, nystagmus, dystonia, epistaxis, tachycardia, arrhythmia, hypertension, tachypnoea, hyperthermia, insomnia, anxiety, paranoia, aggression and violence, stroke, myocardial infarction, tremors, convulsions, seizures, psychosis, overdose and death.
Long Term Harmful Effects		
Dependency, extreme weight loss, malnutrition, addiction, severe dental problems, intense itching, skin sores, anxiety, changes in brain structure and function, confusion, memory loss, sleeping problems, violent behaviour, paranoia, delusions, hallucinations, psychosis, decreased motor skills, language learning decline, mental health disturbance, coronary artery spasm, myocardial ischaemia, myocardial infarction, stroke,	Dependency, potentially fatal physical withdrawal, memory impairment, motor dysfunction, hallucinations, seizures, psychosis, mental health disturbance, incontinence, cardiovascular disease, respiratory dysfunction, toxicity, cardiac failure, kidney failure, liver failure, multi-organ failure, death.	Dependency, sustained bruxism, chronic nystagmus, recurrent dystonia, recurrent epistaxis, extreme weight loss, malnutrition, addiction, severe dental problems, intense itching, skin sores, anxiety, changes in brain structure / function, confusion, memory loss, sleeping problems, violent behaviour, paranoia, delusions, hallucinations, psychosis, decreased motor skills, language learning decline,

atherosclerotic cardiovascular disease, toxicity, cardiac failure, kidney failure, liver failure, multi-organ failure, death.		mental health disturbance, coronary artery spasm, myocardial ischaemia, myocardial infarction, stroke, atherosclerotic cardiovascular disease, toxicity, cardiac failure, kidney failure, liver failure, multi-organ failure, death.
---	--	--

***Note: GBL is a prodrug that is metabolised into GHB in the blood. As such, GBL has a higher potency and quicker onset than GHB.**

HIV

GBMSM who participate in chemsex may also be at increased risk of acquiring HIV either through sex or through sharing injecting equipment when participating in slamsex (59–62). A recent prospective cohort study of GBMSM in London and Brighton found that men who reported participating in chemsex were 6.45 times more likely to be diagnosed with HIV (62). This risk increased to 27.96 amongst men who reported slamsex. However, given small sample sizes in this study and the presence of observed and unobserved confounding variables, this association cannot be viewed as causal. Furthermore, other studies report that participation in chemsex is more common amongst GBMSM living with HIV compared to HIV-negative GBMSM and that engagement in chemsex can come as a response to HIV diagnosis, showing that chemsex and HIV status may be bi-directionally associated (5,7,63). Additionally, studies have reported that GBMSM who engage in chemsex and are not living with HIV may be more likely to be on PrEP, compared to HIV-negative GBMSM who do not engage in chemsex (41). Amongst GBMSM living with HIV, participation in chemsex has been shown to negatively impact adherence to HIV medication and HIV clinic attendance, increasing odds of detectable viral load and, consequently, risk of HIV transmission to other sexual partners (7,63,64). At the same time, other studies detail that HIV-positive GBMSM who participate in chemsex engage in serosorting—an HIV prevention measure whereby individuals living with HIV only have sex with other individuals living with HIV—during chemsex as a tool to prevent transmission of HIV (2,7).

STIs

Recent cross-sectional and cohort studies using predictive modelling and observational methods have found that participation in chemsex is associated with decreased use of condoms during sex, greater numbers of sexual partners, and increased odds of acquisition of STIs amongst GBMSM—including syphilis, chlamydia, and gonorrhoea (61,65–67). At the same time, GBMSM who engage in chemsex report higher rates of attendance at sexual health services and recent testing for STIs compared to GBMSM who do not engage in chemsex (41,68). Amongst people who engage in regular chemsex, risk of STIs has been found to be greater amongst GBMSM living with HIV, GBMSM who practise slamsex, and GBMSM who engage in chemsex with multiple partners, as opposed to chemsex with one other partner (67,68).

Viral hepatitis

Fewer studies detail the association of chemsex participation with Hepatitis C (HCV) and Hepatitis B (HBV). Across studies, researchers report an estimated prevalence of HCV infection of 6%-30% amongst GBMSM who engage in chemsex, with the majority of people who acquire HCV being individuals already living with HIV (7). While risk of acquiring HCV through anal sex is lower than other routes—such as sharing injecting equipment—previous STI infection and positive HIV status increase biological risk of HCV acquisition due to micro damage to the mucosal barrier in the rectum (69). Given the high risk of HCV transmission through sharing injecting equipment, GBMSM who engage in slamsex have increased odds of HCV acquisition compared to GBMSM who practice chemsex but do not slam chems; however, no data exist on the incidence of HCV amongst GBMSM in the UK due to slamsex (22). Similarly, no data currently exist showing the incidence of HBV amongst GBMSM engaged in chemsex, however, factors associated with chemsex, such as frequent condomless anal intercourse with multiple sexual partners and sharing injecting equipment when practising slamsex, are also risk factors for HBV infection.

Other infections and diseases

No data currently exist detailing the incidence or risk of other infectious diseases amongst people who engage in chemsex; however, previous research has demonstrated associations between drug use (outside of chemsex) and other types of infections (59). People who smoke drugs may be at increased risk of respiratory infections, including COVID-19, due to sharing inhalation equipment (70). Furthermore, people who smoke drugs, including methamphetamines, are at increased risk of respiratory diseases like chronic obstructive pulmonary disease (COPD) due to unsafe, makeshift inhalation products (70,71). Unlike injection supplies, it is currently prohibited in the UK to distribute inhalation products for the purpose of harm reduction. People who inject drugs are at increased risk of bacterial infections, such as cellulitis, thrombophlebitis, vasculitis, infectious endocarditis, and septicemia (sepsis), due to recurrent injection without proper aseptic technique (72).

Mental health

Recent systematic reviews of studies examining chemsex participation have found that participation in chemsex is associated with poor mental health and limiting mental health conditions such as, anxiety, depression, paranoia, and drug-induced psychosis (23,41,73,74). However, these studies also posit that GBMSM+TGNC who have poor mental health may be more likely to engage in chemsex as a way to cope or mask pre-existing underlying mental health conditions, meaning that chemsex and poor mental health may also be bidirectionally associated. For some GBMSM+TGNC, participating in chemsex opens them up to a community of like-minded people with whom they are able to form satisfying and intimate platonic, romantic, and sexual connections (8,23). However for others, chemsex may exacerbate personal challenges. Negative situations that may occur during chemsex or within the chemsex community—including breach of consent, sexual assault, and intimate partner violence—may contribute to emergent poor mental health and conditions, like post-traumatic stress disorder,

that were not present before engaging in chemsex (16,19). Though limited, research has noted that GBMSM+TGNC who experience poor mental health related to chemsex are at increased risk of suicidal ideation (18,73,75).

Repeated and long-term use of chems can lead to lack of sleep resulting in increased paranoia and potential psychosis (22,75). Risk of psychosis may be greater amongst GBMSM+TGNC who use methamphetamine, especially those who inject methamphetamine (74). While frequent use of any of the three major chems can carry risk of psychological dependence, GHB/GBL carries risk of physical dependence, even greater than the risk of opiates or alcohol (53,54,76). Withdrawal from GHB/GBL for dependent individuals also carries a higher risk of death than withdrawal from opiates or alcohol and requires intensive specialist intervention and inpatient detoxification (54,76).

GBMSM+TGNC who engage in chemsex may also experience a type of psychosociosexual dependency of chemsex (22,23,75). Chemsex may become the only way that men can achieve sexual arousal, emotional intimacy, or sexual satisfaction with partners. However, continued participation in chemsex sessions may leave men with limited social connections outside of the chemsex 'scene'. Qualitative research details that GBMSM+TGNC may find themselves trapped in negative patterns of chemsex followed by severe depressive symptoms, acute psychosis, shame, and self-loathing during comedowns that lead them to consider suicide as the only option to break this cycle (73).

Local findings

There is very limited data from national health databases that can be used to estimate the incidence of chemsex-related health harms in City and Hackney. This is because few databases contain data fields that allow for the creation of proxy samples of individuals who engage in chemsex. Therefore, findings should be interpreted with caution, as it is not possible to determine the extent to which engagement in chemsex results in chemsex-related harms.

Still, all interviewed professionals expressed significant concerns about rising health harms of methamphetamine and GHB/GBL use (4). A recent unofficial review from the London Ambulance Service (LAS) on chemsex-related callouts in the last three years found that there were roughly 30 ambulance callouts a month across London for incidents relating to GHB/GBL, methamphetamine, and/or mephedrone, with the highest numbers centred around the Vauxhall and Soho neighbourhoods. LAS also estimated roughly 3 chemsex-related deaths a month in London from this review.

Data from local services coupled with qualitative insights from interviewed professionals is the best data available to describe local chemsex-related health harms. SHL data provide some information on the HIV, STI, and viral hepatitis test positivity rates of GBMSM+TGNC who report ever having sex while under the influence of substances.

Drug-related risks and harms

Data from local death registrations show five deaths in City and Hackney since 2019 where the listed cause of death was acute drug toxicity involving GHB/GBL, methamphetamine, and/or mephedrone. However, it is unknown if these deaths can be attributed to chemsex, as decedents may have used these drugs recreationally in contexts that would not be defined as chemsex. While not specific to City and Hackney, one study from 2017 conducted in London found that GHB/GBL-related deaths increased between 2014 and 2015. Data available from the ONS also report that the number of deaths due to drug poisoning in London where GHB/GBL is listed as a factor on the death certificate has increased in recent years (77).

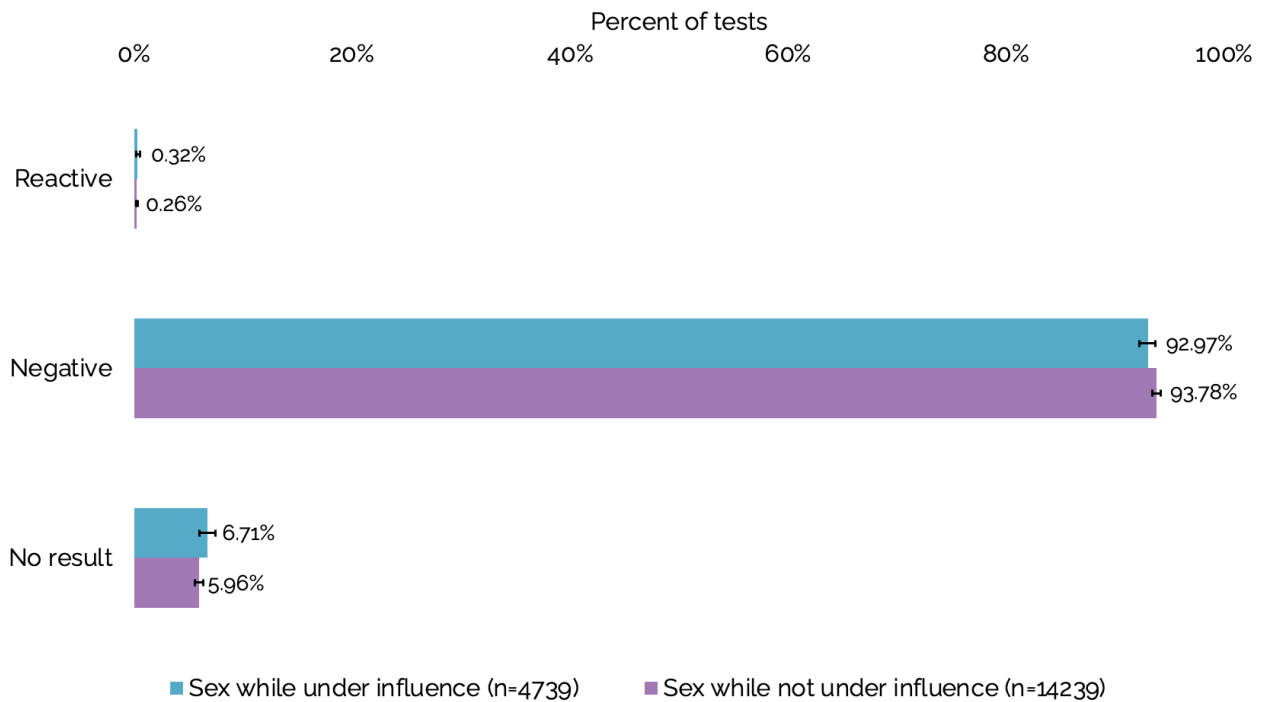
There are no local data on the number of LAS callouts or hospitalisations related to overdose of methamphetamine, GHB/GBL, or mephedrone; however, interviewed professionals believed that the number of local overdoses, including nonfatal overdoses, and ambulance callouts has increased in recent years (4). This was thought to be due to several factors, including an increase in chems use amongst younger and more drug-naïve GBMSM and an increase in the visibility of chemsex and chems-related harms, leading to more ambulance callouts.

HIV

Data from Antidote and the HSHS chemsex service do not provide information on acquisition of HIV amongst service users; however, they do provide information on the HIV status of individuals engaged in services. Fourteen percent of Antidote service users from City and Hackney in FY 23/24 were living with HIV and one third of individuals referred for chemsex support at HSHS were living with HIV. Amongst the cohort of individuals referred to the HSHS chemsex who were living with HIV, 26% reported that chemsex had negatively affected their adherence to HIV medication.

Unlike demographic data, SHL data on sexual health testing kit results are reported at the test-level. As such, true positivity rates for kits tested between 2022-2024 can be calculated. Only a small minority of testing kits (0.32%, CI: 0.19%-0.52%) that were submitted by GBMSM+TGNC from City and Hackney who reported having sex while under the influence of drugs or alcohol tested reactive for HIV antibodies (43). This was similar to the proportion of reactive tests submitted by GBMSM+TGNC who reported not having sex while under the influence of drugs or alcohol (0.26%, CI: 0.19%-0.36%) (Figure 18). There was no significant difference in the odds of reactive result between GBMSM+TGNC who reported sex while under the influence of drugs or alcohol and those who did not report having sex while under the influence of drugs or alcohol.

Figure 18. HIV test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.



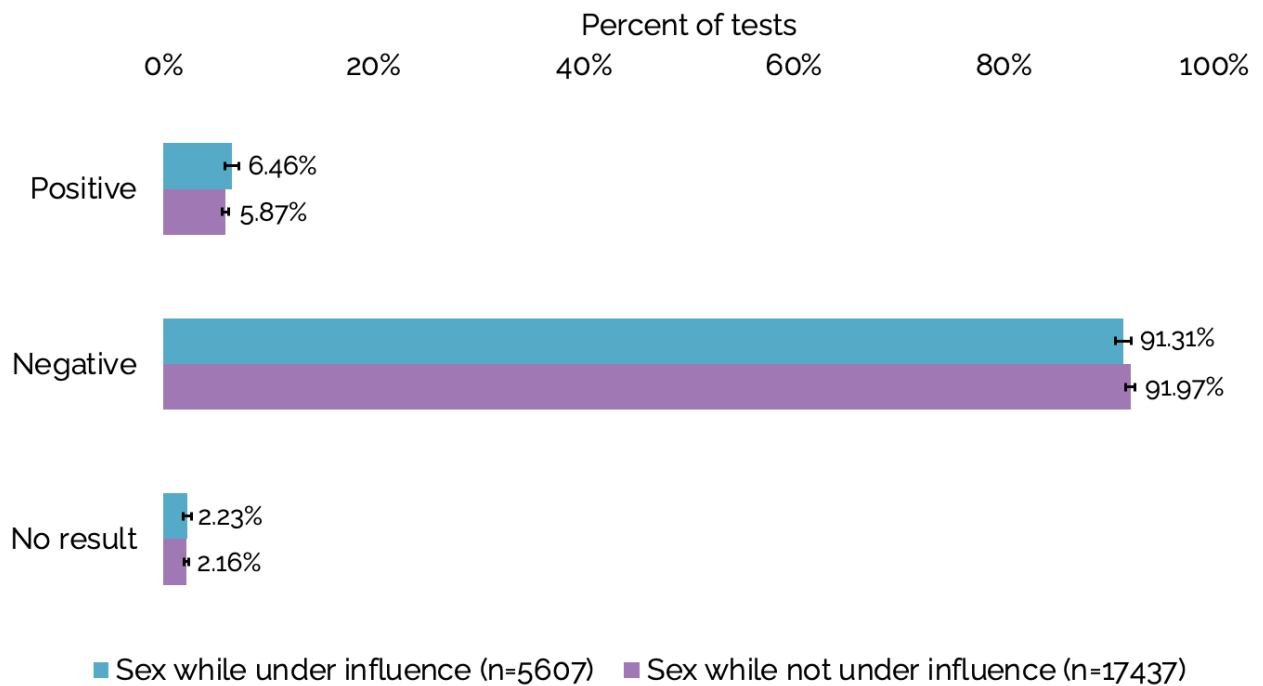
Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

STIs

There are no data available from local chemsex services on the incidence of other STIs amongst service users; however, SHL data can again provide insight into the test positivity rate amongst individuals who took at-home STI tests and reported having sex while under the influence of drugs or alcohol.

The proportion of kits testing positive for chlamydia was similar between GBMSM+TGNC who reported having sex while under the influence of substances (6.46%, CI: 5.84%-7.13%) compared to those who reported never having sex while under the influence (5.87%, CI: 5.53%-6.23%) (Figure 19).

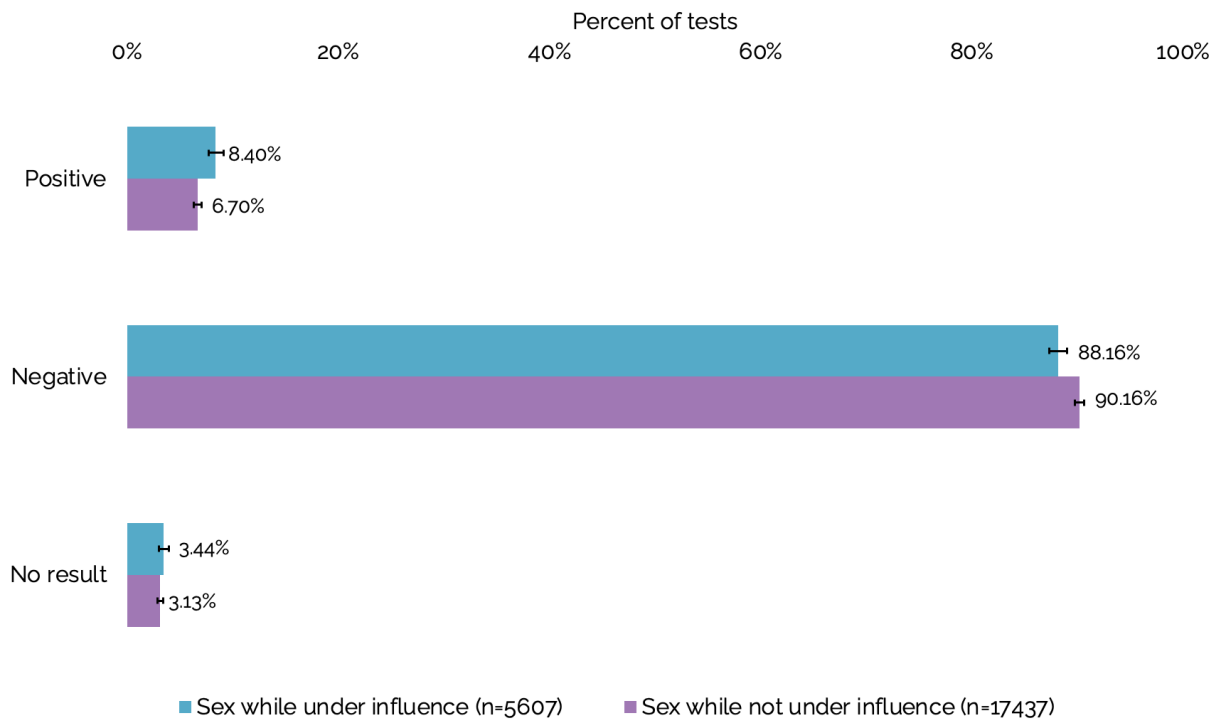
Figure 19. Chlamydia test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.



Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

Notably, testing kits ordered by GBMSM+TGNC who reported having sex while under the influence of drugs or alcohol had a higher test positivity rate (8.40%, CI: 7.70%-9.16%) for gonorrhoea compared to kits ordered by GBMSM+TGNC who did not report having sex under the influence of drugs or alcohol (6.71%, CI: 6.34%-7.09%) (Figure 20).

Figure 20. Gonorrhoea test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.

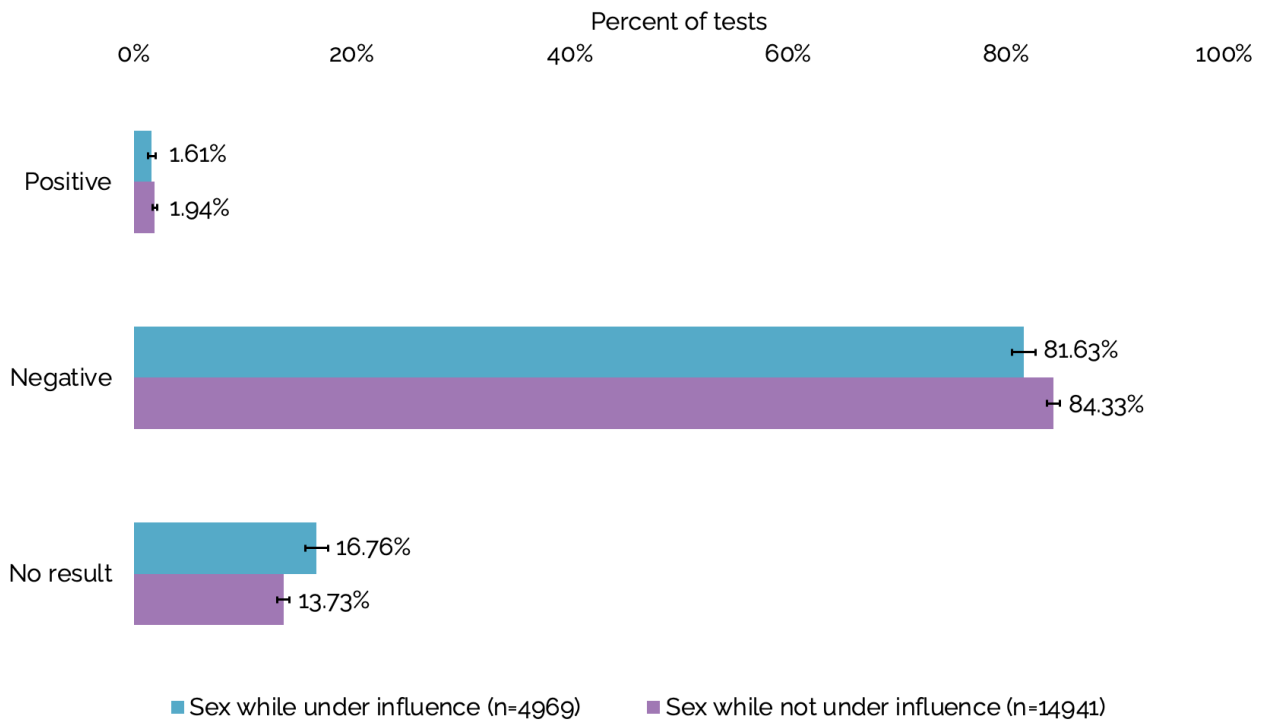


Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

This difference was statistically significant; testing kits ordered by GBMSM+TGNC who reported having sex while under the influence of drugs or alcohol had 1.28 higher odds (CI: 1.15-1.43) of being positive for gonorrhoea compared to kits ordered by GBMSM+TGNC who did not report having sex while under the influence of drugs or alcohol.

Fewer kits tested positive for syphilis. There was no significant difference in the test positivity rate between GBMSM+TGNC reporting having sex while under the influence of drugs or alcohol and GBMSM+TGNC not reporting sex while under the influence of drugs or alcohol (Figure 21).

Figure 21. Syphilis test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.



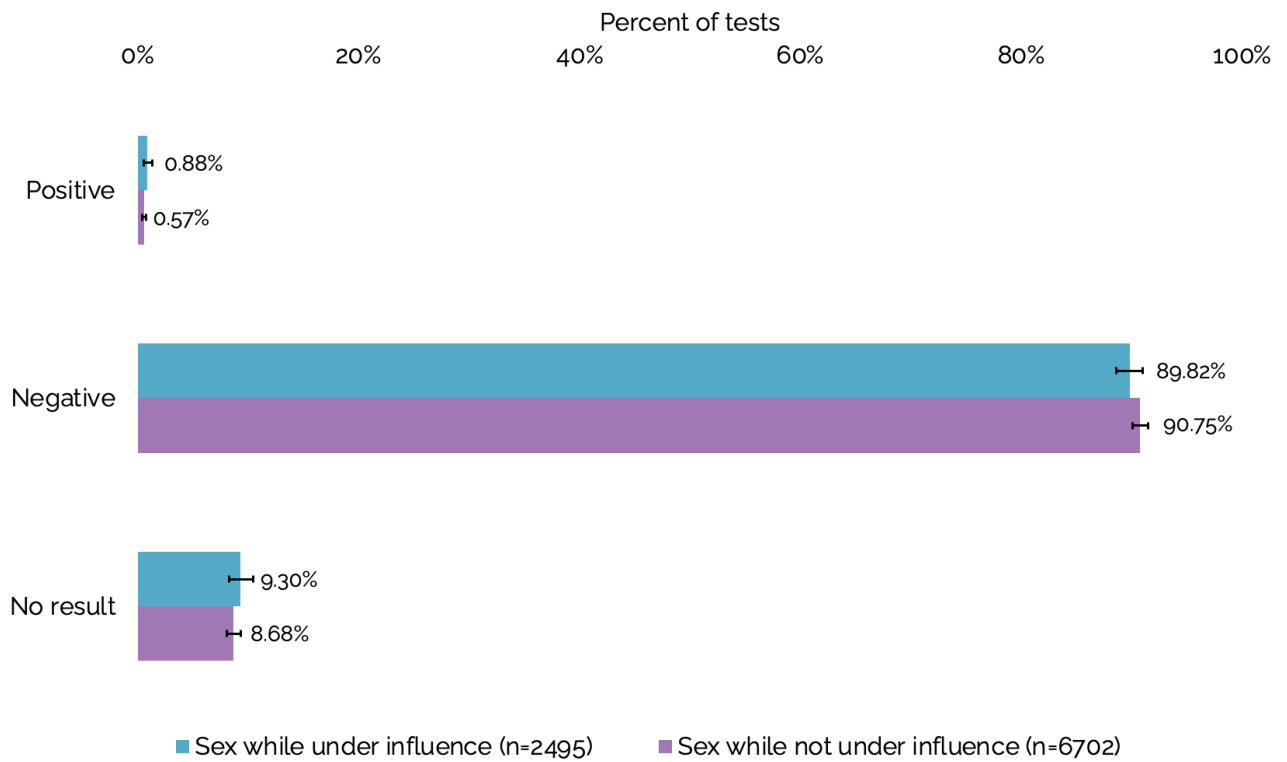
Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

Viral hepatitis

Similarly, there are no data available from local chemsex services on the incidence of HBV or HCV amongst service users.

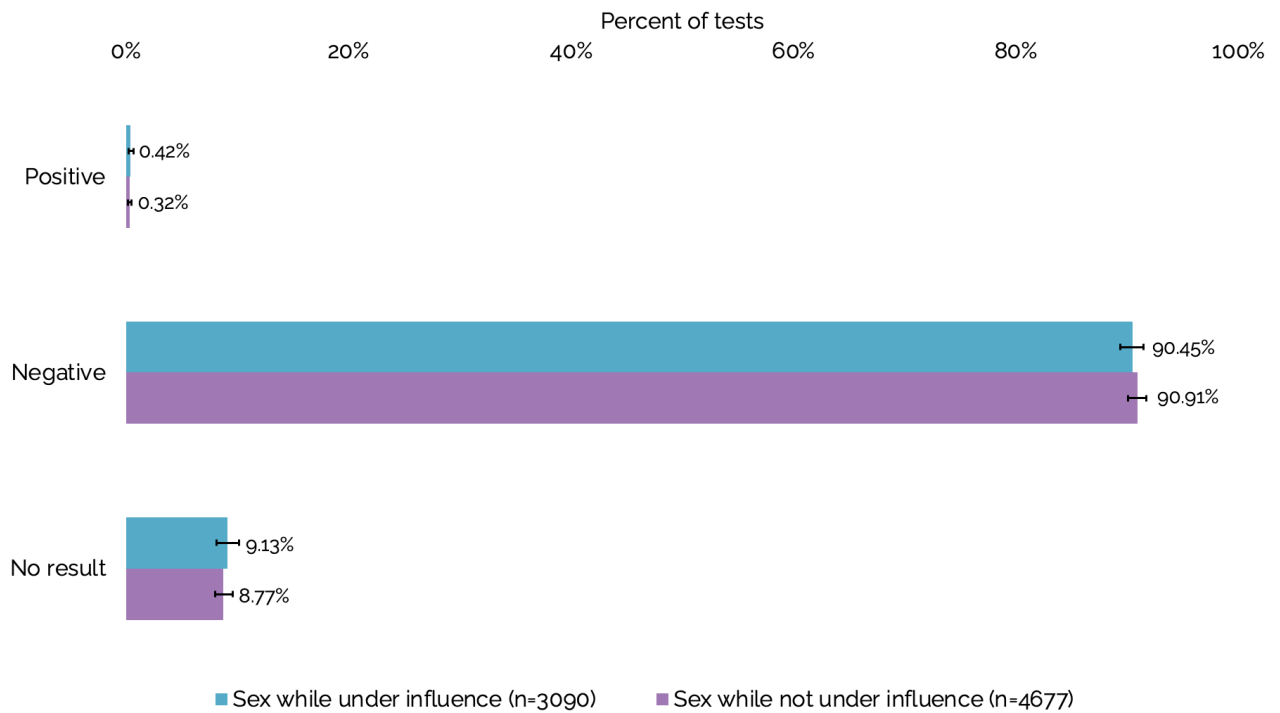
Very few test kits ordered by GBMSM+TGNC from SHL who reported having sex while under the influence of substances tested positive for HBV or HCV (Figures 22 & 23). These proportions were similar to the positivity rates of tests submitted by GBMSM+TGNC who did not report having sex while under the influence of drugs or alcohol.

Figure 22. HBV test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.



Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

Figure 23. HCV test results of SHL test kits ordered by GBMSM+TGNC in City and Hackney by reported engagement in sex while under the influence, 2022-2024.

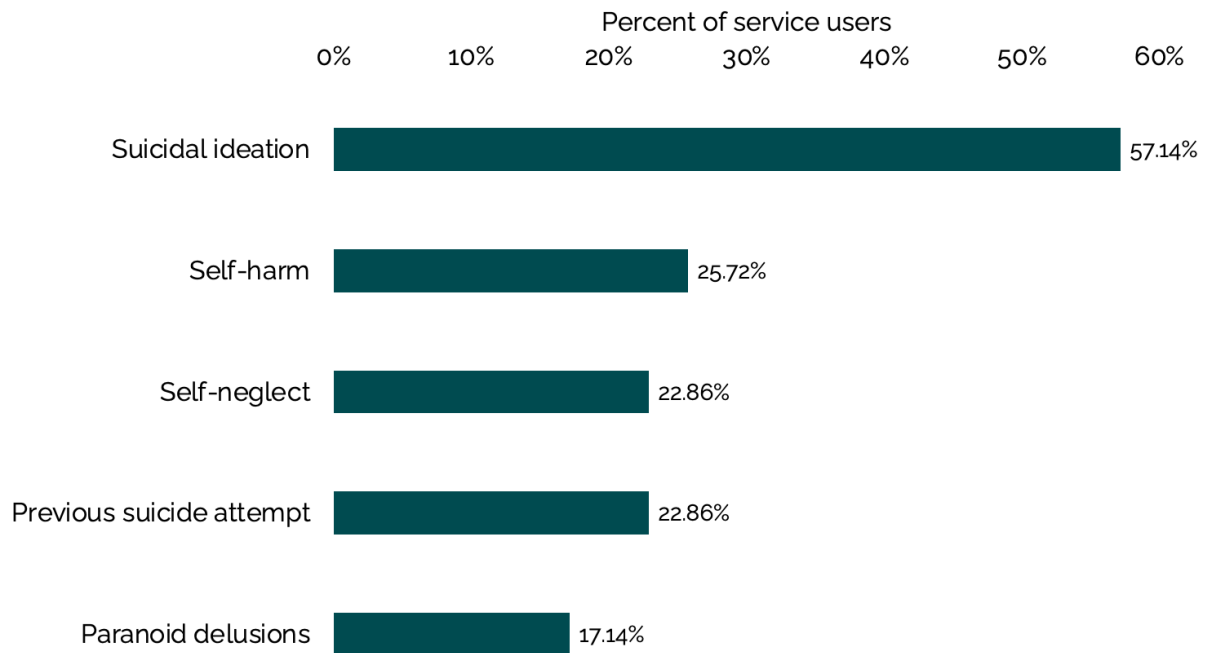


Source: Preventx. SHL at-home testing kits from the City of London and Hackney, 2022-2024. 2025.

Mental health

The service user reports from Antidote and the HSHS chemsex service provide an initial understanding of the prevalence of mental health concerns amongst GBMSM in City and Hackney receiving support for chemsex (Figure 24) (44,45).

Figure 24. Reported mental health concerns of Antidote service users from City and Hackney (n=35), FY 23/24.

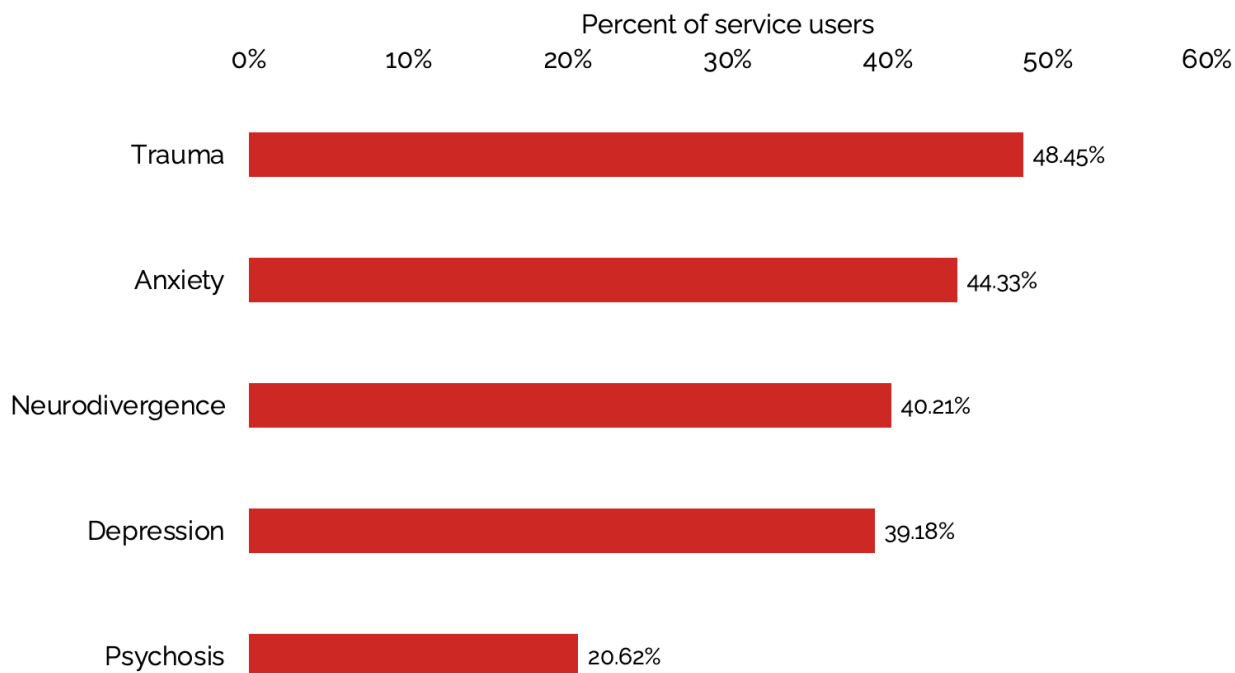


Source: Moncrieff, M. Antidote service user report: Hackney and the City of London (23/24). 2024.

More than half of Antidote service users reported previous or current suicidal ideation (57.14%). This was followed by current or previous self harm (25.72% reporting), and current self-neglect (22.86% reporting).

The HSHS chemsex service captured different types of mental health comorbidities amongst service users, with a substantial proportion of individuals referred to the service reporting trauma, anxiety, or depression (Figure 25) (44).

Figure 25. Reported mental health concerns of individuals referred to the HSHS chemsex service (n=60), FY 24/25.



Source: Revez, A. et al. High risk sex and chemsex service annual report: 2024-2025. 2025.

The HSHS chemsex service also found a large proportion of individuals referred to the service reporting neurodivergence (40.21%), including undiagnosed neurodivergence. This was described in more detail by interviewed professionals who mentioned that neurodivergence may be more common amongst GBMSM who engage in chemsex as drugs used in chemsex, specifically methamphetamine, are similar to those prescribed for conditions like attention deficit/hyperactive disorder (ADHD); therefore, GBMSM may self-medicate for these conditions through chemsex (4).

Again, these data cannot serve as prevalence estimates for mental health needs of GBMSM in City and Hackney who engage in chemsex given that they only reflect a small fraction of the population who are currently engaged in support services. However, they broadly align with the types of mental health concerns amongst the population of GBMSM engaged in chemsex, as seen in the literature.

Interviewed professionals also echoed sentiments in the general literature, sharing that many GBMSM who engage in chemsex may do so to cope with poor self-esteem, loneliness, trauma, and social stigma around being gay or living with HIV (4). As expressed in interviews, GBMSM may also consider or even attempt suicide, either intentionally as a way to relieve psychotic symptoms or unintentionally as a result of misadventure during a psychotic episode (4). Interviewees shared that chemsex can severely disrupt GBMSM's wider lifestyle, with men losing

partners, accommodation, family, jobs, and social connections, leading men to become further dependent on chemsex and the chemsex 'scene' to achieve momentary pleasure and fulfilment (4). Professionals also universally expressed that this sizable burden of mental health needs amongst GBMSM who engage in chemsex is often unmet because local mental health services may not feel equipped to support co-occurring substance use and mental health and may even reject referrals for mental health support when there is co-occurring substance use (4). This results in a 'revolving door' in which individuals experiencing poor mental health repeatedly engage with crisis services only to be discharged without appropriate ongoing support, placing additional strain on emergency services.

4.4 Social risks and harms

General findings

Employment and housing

More recently, professionals have noted increasing links between chemsex and other social harms, including loss of employment, homelessness, and self-neglect (10,18,28,78). Research into the association between chemsex and these harms is extremely limited and assertions have largely been driven by public media. These pieces describe how increased engagement in chemsex devolves into similar social needs experienced by other groups of individuals who use drugs: developed dependence interferes with individuals' ability to maintain jobs and housing, leading to loss of employment and/or homelessness (27,28,78). One recent longitudinal study from the United States found a reverse correlation between chemsex and homelessness, with GBMSM who had a history of homelessness being at increased risk of future substance use and chemsex engagement (79). These findings also echo stories in public media that describe experiences of younger homeless GBMSM beginning to engage in chemsex as a form of sex work in exchange for shelter and food and then developing dependence both to chems as well as to the exploitive relationships with others in the chemsex scene.

Chemsex-related crime

In recent years, researchers and practitioners have paid more attention to potential links between chemsex and criminal activity, especially following the high profile case of Stephen Port, an east London resident who was found guilty in 2016 on multiple counts of sexual assault, rape, and murder related to chemsex activity (26). Homicide, such as in this case, represents the far extreme end of chemsex-related crime. Exact prevalence estimates of criminal behaviour amongst people who engage in chemsex do not exist. Researchers and practitioners believe that victims of chemsex-related crime, including sexual assault and rape, may not report cases because of perceived stigma, including homophobia, from police and other professionals in the criminal justice system (20,80). Findings from an analysis of HMPPS data from England and Wales collected between April 2019-March 2020 found that, of the total number of potential chemsex-related offender encounters with the criminal justice system (147), the most common

offences were drug-related offences (possession and/or supply), followed by violence without injury, and other sexual offences (excluding rape) (21).

Consent, sexual assault, and exploitation

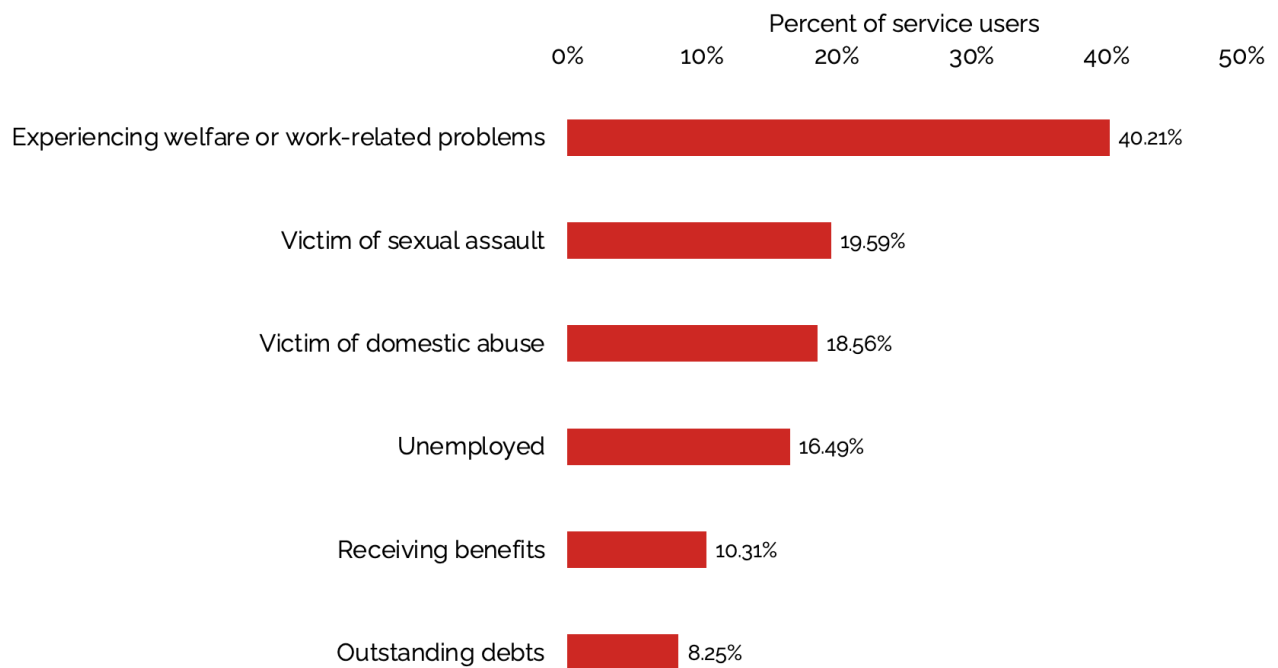
During chemsex sessions, individuals may lose capacity to consent to certain drug-taking or sexual activities given potentially altered states brought on by use of chems. As such, GBMSM who engage in chemsex may be more likely to experience unwanted touching and rape compared to GBMSM who do not engage in chemsex (12,19). In rare cases, sexual partners may deliberately use chems, most commonly GHB/GBL, to incapacitate individuals in order to carry out sexual acts, including rape (29).

Furthermore, given the potentially coercive nature of chemsex sessions and relationships between individual who engage in chemsex, consent may not always be given or withdrawn freely during chemsex and GBMSM may feel pressure or pressured by others to consume more drugs or engage in unwanted sexual acts (12). Overtime, this can lead to financial or sexual exploitation, especially amongst GBMSM who engage in chemsex as part of sex work. GBMSM who engage in chemsex can also experience sexual violence through non consensual documenting of chemsex sessions and sharing these explicit images or videos, also known as 'revenge porn'. This issue became heightened during the COVID-19 pandemic when GBMSM engaged in solo chemsex (use of chems and masturbation) in large virtual video rooms which in some instances, were live streamed or documented without participants' consent (81). These traumatic experiences of non consensual drug-taking and sexual activity can result in severe, complex, and enduring poor mental health amongst GBMSM who engage in chemsex.

Local findings

Very little data are available detailing local social harms of chemsex, and thus, it is not possible to estimate the proportion of people who engage in chemsex who may experience social harms related to chemsex. The only local information on reported social risks and harms comes from the HSHS chemsex service (Figure 26).

Figure 26. Reported social problems of individuals referred to the HSHS chemsex service (n=60), FY 24/25.



Source: Revez, A. et al. High risk sex and chemsex service annual report: 2024-2025. 2025.

Amongst individuals referred to the service, the most common social harm experienced by individuals was welfare or work-related problems (40.21%), such as poor work attendance, difficulties in maintaining working hours, and difficulty in keeping up with general life administration. Almost 20% of individuals referred to the service reported experience of sexual assault and/or domestic abuse.

The majority of local information on specific chemsex-related social risks and harms comes from interviewed professionals, reported in the following sections.

Employment and housing

Interviewed local professionals expressed fewer concerns about other social risks related to chemsex; however, they did note that more frequent engagement in chemsex can increase risk of dependence (4). This dependence can negatively affect individuals' ability to maintain a job and can result in loss of employment, in turn leading to loss of housing due to inability to pay rent. There are no local data on the number of individuals claiming unemployment, housing, or other benefits as a result of engagement in chemsex.

Chemsex-related crime

The types of chemsex-related crimes described by interviewed professionals were broadly similar to those described in the literature, including serious physical assault and domestic violence, non-consensual distribution of indecent images, blackmail, harassment, robbery and theft, financial exploitation, and stalking (4). Some professionals also described limited experiences of chemsex-related cuckooing, a practice where individuals may take over another person's residence for the purpose of exploiting that person and/or others. Interviewees described many of these crimes as opportunistic acts targeting other, more vulnerable GBMSM during chemsex sessions. However, given the potentially dependent and exploitative nature of chemsex, these acts may escalate over time through prolonged engagement in chemsex and the chemsex 'scene' into more serious and organised criminal activity.

Interviewees also described experiences where engagement in criminal offences was precipitated by altered mental states due to chems use (4). This was described as a greater risk amongst GBMSM who use methamphetamines, as they may experience increased paranoia or induced psychosis, leading them to engage in illegal activity, such as possession of an offensive weapon, in response to perceived threats.

Most notably, interviewees expressed that, given the dynamic nature of chemsex sessions and chemsex communities, GBMSM who engage in chemsex and come to the attention of the criminal justice system may be both a victim and a perpetrator of crimes simultaneously for the same incident (4). This duality further acts as a barrier to reporting, prosecuting, and understanding the nature of chemsex-related crime.

Consent, sexual assault, and exploitation

Professionals also noted similar themes as those described in the literature regarding difficulties in providing consent and risk of sexual assault and exploitation, though perspectives differed on the extent of these risks in the local environment (4). Some described that GBMSM may choose to engage in chemsex only with close, trusted friends to reduce risk of sexual assault, which was seen as greater in larger, anonymous chemsex settings. Some also described that in some chemsex settings, hosts of chemsex parties may act as unofficial caretakers to ensure that all individuals respect rules of consent. Some also described that 'rules' of consent may be planned in advance of chemsex parties, so that individuals know beforehand what type of sexual behaviour is acceptable by other participants before taking chems and consent can be assumed for those acts. At the same time, interviewees acknowledged that even in more structured chemsex environments, individuals may still engage in unwanted sexual behaviour and can be at risk of sexual assault and rape, particularly if individuals may be disoriented or unconscious from GHB/GBL.

4.5 Harm reduction and support services

General findings

Harm reduction

Given the unique context and set of harms associated with chemsex, researchers and practitioners have pioneered bespoke interventions and programmes for chemsex-related harm reduction (17,82,83). A recent review by Strong et al., categorises these strategies by the types of harm they reduce (Table 8) (60).

Table 8. Reported types of harm and associated harm reduction strategies in Strong et al. review.

Type of harm	Harm reduction strategies
Drug-related harm: overdose, dependence	Boundary setting Peer monitoring of vital signs and consciousness Nutrition and hydration Rest and self-care Needle and syringe provision Information, education, and communication
HIV-related harm: HIV transmission/acquisition, poor adherence to HIV medication	Needle and syringe provision Peer and electronic-based adherence techniques for HIV medication HIV testing and counselling PrEP Condoms Post-exposure prophylaxis for HIV (PEP) Information, education, and communication
Sex-related harm: STI and	HAV, HBV, and HPV vaccinations

viral hepatitis transmission/acquisition, bodily injury	STI & viral hepatitis testing and treatment Condoms Doxycycline used as post-exposure prophylaxis for STIs (DoxyPEP)
---	--

A further review on harm reduction for chemsex details additional strategies that GBMSM, themselves, employ as individuals, interpersonal pairs, and communities to reduce these and other harms, such as sexual assault (11). These strategies include planning and structuring drug use and dosing, taking periodic breaks from chemsex activity, and engaging in group chemsex sessions with 'buddies' or tasking chemsex party hosts to watch out for others' safety.

Support

The structure of support services for chemsex varies globally, but recent guidance from the British Psychological Society, as well as global research on models and experiences of support services, stress the need for integrated care through specialist clinics located within sexual health services and other LGBTQIA+ community-based organisations, rather than traditional drug and alcohol treatment services (84–86). These integrated care models allow GBMSM access to a range of relevant supports, such as psychological interventions; STI and viral hepatitis prevention, screening, counselling, treatment/care; and bespoke harm reduction guidance for chemsex, in one space. Professionals in sexual health services and LGBTQIA+ community organisations often have greater knowledge and competencies in understanding the contexts and potential risks of chemsex and greater established trust and rapport with GBMSM compared to traditional drug and alcohol treatment services (84). Therefore, GBMSM who engage in chemsex may be more likely to approach these services for chemsex-related concerns. Specific therapeutic approaches to support individuals engaged in chemsex vary widely and include elements of motivational interviewing, cognitive behavioural therapy, contingency management, group-based work, as well as pharmacological interventions for GBMSM experiencing psychosis (60,74,84,85,87). There is limited research, however, detailing the long-term effectiveness of these interventions and there are no current quality standards on treatment for chemsex dependence.

Local findings

Harm reduction

Many interviewed professionals expressed that harm reduction approaches are critical to addressing the local public health concerns of chemsex. This is partly because for many individuals, engagement in chemsex does not result in extreme harm and, given the right tools, individuals are able to engage in chemsex while mitigating the risk of negative consequences.

Professionals expressed that traditional drug and alcohol treatment services are often not equipped to support GBMSM who engage in chemsex with these bespoke harm reduction interventions. This is due to lack of provision of specific tools like PrEP, PEP, and rapid STI/viral hepatitis testing; lack of knowledge by providers about the specific risks of and contexts of chemsex and chems use; and stigma felt by GBMSM who engage in chemsex from drug and alcohol treatment providers, which serves as a barrier to engagement (4). Instead, individuals who engage in chemsex may seek harm reduction advice and tools from LGBTQ+ community groups because they are seen as less stigmatising and more understanding of the communities culture and needs.

Several organisations provide harm reduction materials and interventions in City and Hackney specific to chemsex, and are described below. No quantitative data are currently available to assess the access or impact of these services.

The Love Tank is a grassroots Community Interest Company based in East London that conducts regular in-person outreach to GBMSM and minority queer communities regarding health promotion and sexual health. As part of this outreach work with partner LGBTQIA+ organisations, The Love Tank disseminates informational resources and education detailing harm reduction strategies for chemsex, including self-care and preparation, drug preparation and dosing strategies, safer injecting advice, sexual health prevention and testing information, and information on aftercare and supportive services in London. The Love Tank currently runs a pilot programme in City and Hackney to train individuals with lived experience of chemsex in appropriate harm reduction interventions and distributes injecting equipment and other harm reduction paraphernalia to LGBTQ+ people who use drugs, including chems.

Gay Men's Health Collective (GMHC) is a London-based umbrella organisation that produces printed educational materials and videos on harm reduction strategies for people who engage in chemsex. These materials include information on self-care, safer drug use strategies, sexual health prevention and testing, and advice on interacting with emergency services and the criminal justice system. GMHC also packages and disseminates chemsex harm reduction kits, called 'PIP PACS', which contain printed informational materials as well as condoms and lubricant, drug preparation materials, drug dosing templates, dose measuring equipment, and colour-coded injecting equipment and disposal packs to reduce sharing of equipment. Kits are currently available online and disseminated through the City and Hackney Recovery Service and by HSHS. GMHC also partners with the LAS to disseminate confidential online information regarding chemsex support and harm reduction.

Partnered with **City and Hackney Recovery Service, London Friend's Antidote** project runs an anonymous helpline on weekdays that provides harm reduction advice to GBMSM on safer chem use and chemsex. Antidote also runs a weekly drop-in clinic with a sexual health advisor to provide in-person harm reduction advice and linkage to services.

HSHS provides a range of services for GBMSM engaged in chemsex, including online and material resources on harm reduction strategies for safer use of chems and chemsex. Clinics operated by these services also provide rapid STI and viral hepatitis testing, and prevention tools, including PrEP and PEP as harm reduction tools for GBMSM engaged in chemsex.

The following services provide bespoke harm reduction services for chemsex across London, but are not specific to City and Hackney:

Controlling Chemsex operates across London and offers both in-person and online harm reduction support. Harm reduction advice includes information on self-care, safer drug consumption and injecting practices, and STI and viral hepatitis prevention. Controlling Chemsex also operates an anonymous service on geosocial networking apps like Grindr where GBMSM can receive point-in-time advice and linkage to support services.

To address criminal-justice related harms of chemsex, **Project Sagamore** was established in 2020 as a partnership between the MPS and HMPPS. Working on a pan-London-level, it brings together partners from the criminal justice and health sectors to provide collaborative consultation and coordination for specific chemsex-related crime cases to reduce reoffending and harm.

Support

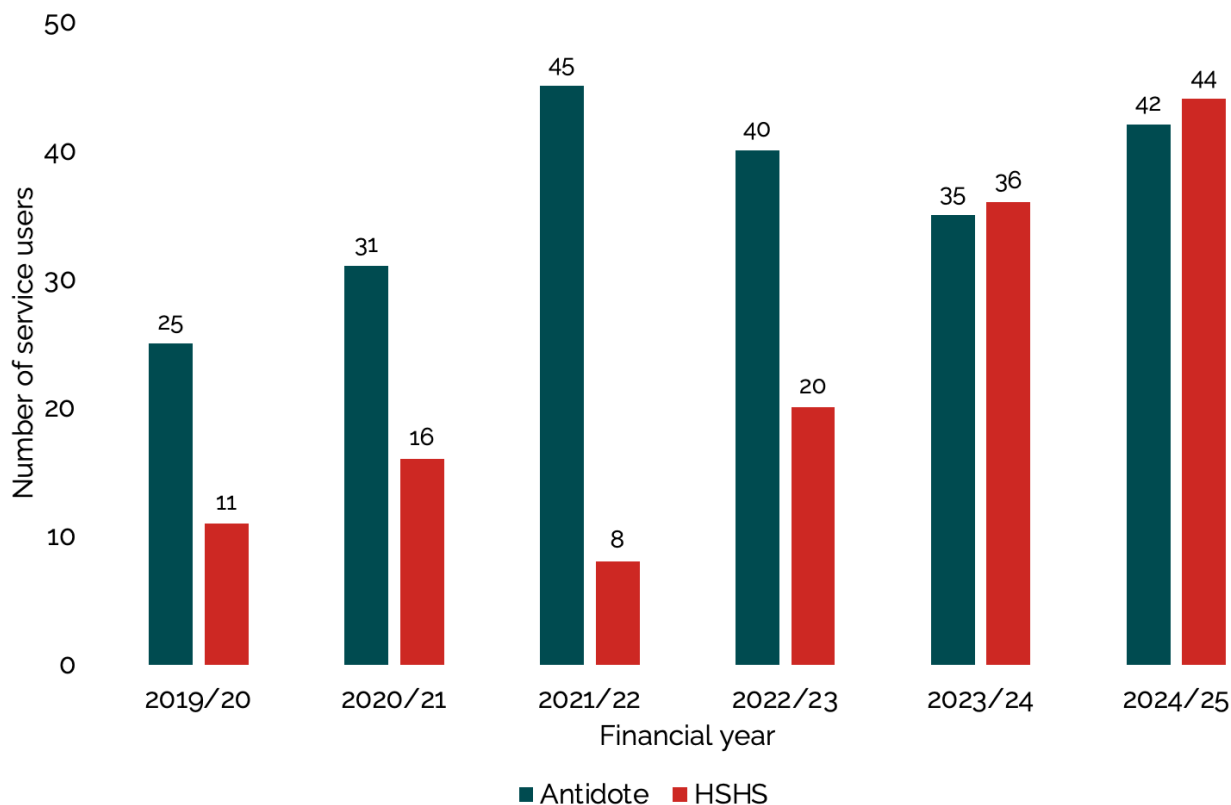
In City and Hackney, specialist support for chemsex is available through the **HSHS chemsex service**, delivered in partnership by **HSHS, the City & Hackney Recovery Service, and Antidote**. Individuals receive one-on-one keyworking sessions from recovery specialists or more intensive, time-limited, individual therapy from a lead clinical psychologist. Professionals in the service work together to develop recovery and care plans tailored to the individuals' support goals, which may include harm reduction, cessation of chemsex, and/or maintenance of abstinence from chems and chemsex. Individuals can receive keyworking support only if they are residents of City or Hackney. GBMSM who live outside of City and Hackney are still able to access support through Antidote outside of their partnership with City and Hackney Recovery Service, as well as high risk sex psychology through HSHS.

56 Dean Street, the **E1 Clinic** at Barts Health, and **Controlling Chemsex** also offer tailored support sessions for GBMSM across London, including those from City and Hackney, but are not specific to City & Hackney. These include one-on-one therapeutic and keyworking sessions to develop bespoke care plans to support GBMSM in stopping, reducing, or controlling their use of chems and participation in chemsex. Some of these services also provide ongoing aftercare services to help men maintain goals following intensive support work. No data are available on the number of GBMSM from City and Hackney using these services.

Overall, the number of service users has increased across Antidote and the HSHS chemsex service in recent years, as shown in Figure 27; however, data are not able to be linked between

services, therefore, individuals may be counted twice if they received support from both Antidote and the HSHS chemsex service.

Figure 27. Number of service users from City and Hackney supported by Antidote or HSHS chemsex service each financial year, 2019/20-2024/25.



Sources: Moncrieff, M. Antidote service user report: Hackney and the City of London (23/24). 2024; Revez, A. et al. High risk sex and chemsex service annual report: 2024-2025. 2025.

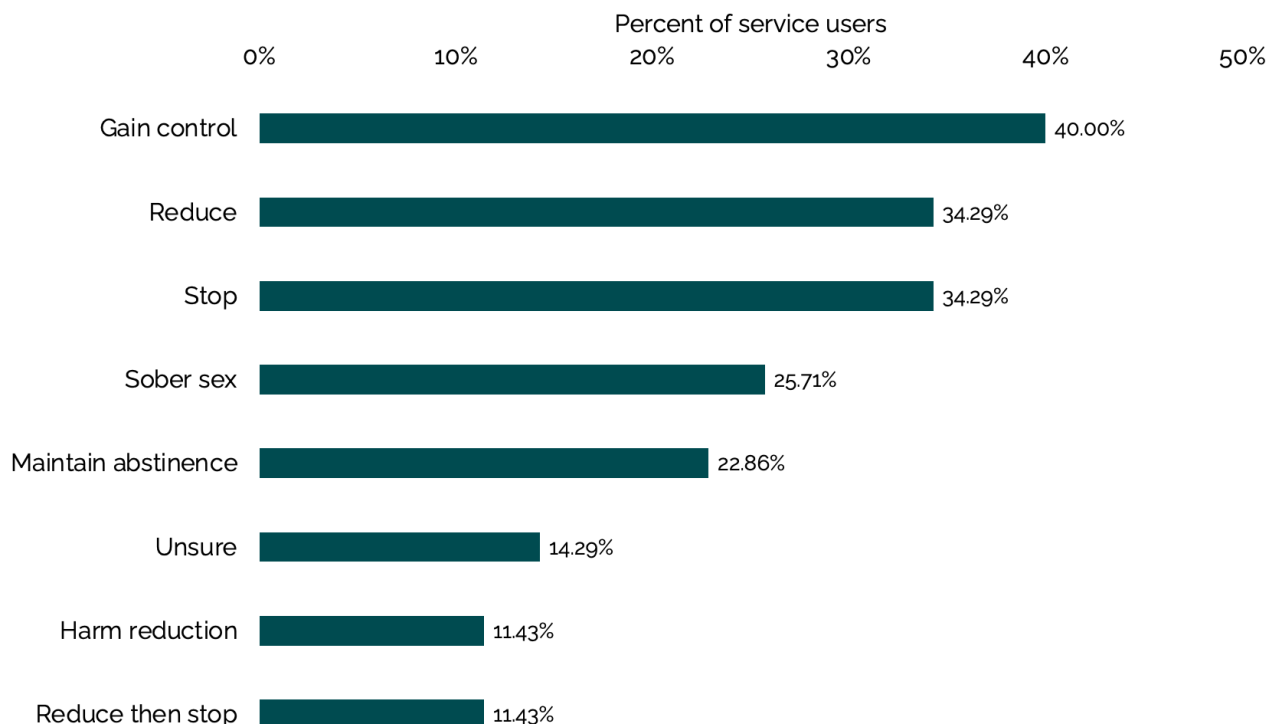
Note: The HSHS chemsex service is run jointly with Antidote, so individuals may be counted as service users in both services.

The increase in the number of individuals being supported does not necessarily mean there is an increased need for chemsex support services in the last few years. This increase may be reflective of improved partnership working and increased capacity within HSHS, the City and Hackney Recovery Service, and Antidote to engage more individuals in support services. Interviewed service providers also noted that there has been an increase in the complexity of the needs of individuals accessing services in the last few years, with more service users presenting with severe drug withdrawal, mental illness, undiagnosed neurodivergent conditions, relationship and intimacy issues, risk of exploitation and criminal justice involvement, and multiple unmet social needs (4).

Service users seen by Antidote between April 2023-May 2024 had mixed support goals at initial assessment, with 40.00% hoping to gain control over their engagement in chemsex, 34.29%

wanting to reduce their engagement, and 34.29% wanting to stop their engagement altogether (Figure 28).

Figure 28. Reported treatment goals of Antidote service users from City and Hackney at initial treatment engagement (n=35), FY 23/24.



Source: Moncrieff, M. Antidote service user report: Hackney and the City of London (23/24). 2024.

Note: Individuals may report more than one treatment goal, so the sum of all columns will not equal 100%.

As noted by service providers in interviews, individual progress relative to support goals is dynamic and often requires longer periods of support than is usually available, given service capacity constraints (4). Many service users often face multiple disadvantages, homelessness, exploitation and abuse, and may also be involved as perpetrators and victims, leading to difficulties in maintaining engagement in services.

Barriers, challenges, and needs

Though there is limited data to quantify the barriers, challenges, and needs of GBMSM in City and Hackney who engage in chemsex, interviews from professionals involved in chemsex harm reduction and support services provide rich qualitative insights on the current local landscape.

While there are more robust services available in City and Hackney for GBMSM who engage in chemsex compared to most other parts of London and the UK, there are still barriers to ensuring

that individuals can access the right type of services to support their needs. The local chemsex support service, run jointly through the City and Hackney Recovery Service, Antidote, and HSHS is not equipped to support individuals experiencing chemsex-related psychosis, those with more severe mental illness, those with personality disorders, or those who pose serious and immediate risk of harm (4). The London Ambulance Service and Homerton University Hospital currently respond to and support with acute chemsex-related overdose events and signpost individuals to outpatient support at this chemsex service; however, patients need more streamlined referral processes to ensure appropriate, closed-loop referrals between these acute health services the network of organisations offering community support for chemsex.

Interviewed professionals expressed that low engagement of GBMSM from black and global majority ethnic communities and transgender and gender diverse individuals with local chemsex support services may represent barriers experienced by these communities in accessing services. The most commonly cited barrier was that these communities may feel that services are more catered to supporting white, cisgender gay men and therefore people from other communities may not feel understood or be able to relate to providers in a way that meets their needs. Professionals noted that one of the key pillars of chemsex support and harm reduction services is that it is provided by or in association with explicitly LGBTQ+ organisations, as service users routinely report that they would be less likely to access support from mainstream services; however, additional work must be done to ensure services are explicitly accessible and acceptable to all members of the LGBTQ+ community, especially those from minority gender and ethnic groups.

In addition to providing more low-barrier, holistic approaches to support, service providers also noted the need for increased harm reduction information and tools that are bespoke to GBMSM who engage in chemsex (4). Controlling Chemsex, GHMC, HSHS, City and Hackney Recovery Service, The Love Tank, and Antidote currently provide various forms of harm reduction advice and material provision which should be scaled up and embedded within traditional sexual health, mental health, and substance use treatment services. At the same time, professionals noted that more support is needed to scale up community-based harm reduction approaches outside of treatment settings, whereby individuals who engage in chemsex themselves are equipped to provide advice, support, and guidance to others on safer chemsex practices and link them with appropriate support services. Providers also advocated for enhanced outreach through geosocial networking apps, like Grindr, where chemsex is facilitated, as well as in-person outreach in nightlife venues where people may later engage in chemsex afterwards at 'chillouts' (4). These spaces are further venues to reach GBMSM and allow for point-in-time harm reduction advice, especially for individuals who may not want to engage in more structured treatment and support.

Paramount to ensuring good-quality support for individuals engaged in chemsex is appropriately joining mental health support with chemsex support services (4). The East London Foundation Trust (ELFT), City and Hackney's secondary mental health service, offers different time-limited and ongoing mental health support services, including intervention for first-episode psychosis. Due to capacity constraints and lack of staff competency in chemsex, however, these

services may not support individuals with mental health needs until their use of chems is addressed and is stabilised (4). Furthermore, first-episode psychosis services do not accept individuals for whom psychosis may be linked to their use of psychoactive drugs. This exclusion criteria creates a gap in service provision for GBMSM who are highly dependent on chems, have ongoing chaotic engagement in chemsex, and may be experiencing severe, complex, and enduring mental health needs. Additionally, there are very few inpatient detoxification placements in London where professionals are skilled to perform specialist GHB/GBL detoxification and community-based detoxification poses too extreme a risk.

Different operational footprints of services, access requirements, and commissioning structures also pose challenges to coordinating care between mental health, substance use, and sexual health services (4). Drug and alcohol services are commissioned by local authorities and can only be accessed by individuals who are residents of that local authority. Mental health services are commissioned by Integrated Care Boards (ICBs) and can be accessed by individuals who are residents of the ICB region or local authority area. Sexual health services, including psychosexual therapy and HIV care, however, are commissioned using a blend of funds from local authorities and ICBs and are open access, meaning that individuals can access services from any sexual health clinic regardless of where they are resident. Interviewees noted that these differences pose tremendous challenges in coordinating care across a variety of different service providers and mean that individuals may not be able to receive specialist chemsex support depending on their area of residence (4).

Chemsex support services also report seeing an increase in the number of service users with needs outside of health services, including housing, employment, domestic violence, and social care (4). Support for these needs is further exacerbated by the lack of affordable and suitable housing within City and Hackney and London, as well as the general cost of living crisis. While the joint chemsex service provided by Antidote, HSHS, and City and Hackney Recovery Service facilitates referrals and signposts service users to relevant services to address these needs, they are not able to regularly provide care navigation or intensive case management, leading some individuals to fall through the cracks. Operational infrastructure to support this type of case coordination between chemsex support services and statutory and other social services is in development in City and Hackney; however, the borough-based model of statutory services like housing, social care, domestic violence, and substance use makes it difficult to ensure long-term coordination of services, especially for individuals who may receive support from open access or pan-London services like NHS sexual health clinics or Controlling Chemsex and live outside of City or Hackney or be placed in out-of-borough temporary accommodation.

Specific challenges in service coordination also exist between support services and criminal justice services (4). Firstly, interviewees expressed that there is a lack of competency and capacity within prison mental health and substance use support services to assess for chemsex and chems dependency and provide culturally competent, holistic support. Coupled with the fact that, upon release from prison, individuals may be placed in out-of-borough accommodation which may not have local chemsex support services, there are technical challenges in linking individuals coming out of prison with community-based chemsex support.

A pilot prison in-reach service run jointly by Antidote and HMPPS has been implemented to address these particular barriers and challenges, but findings have not yet been assessed.

Secondly, given the complexity of chemsex-related crimes, information sharing and case coordination between criminal justice services and support services is challenging, as it may conflict with client confidentiality and privacy (4). Individuals receiving support from a service provider may simultaneously be investigated as both a perpetrator and victim of chemsex-related crime, making it difficult to share case-related information between providers and police to reduce harm. Different individuals and groups of individuals involved in the same case may also receive support from the same services, which, given the dearth of support service provision in City and Hackney and across London, makes it challenging to ensure that service users are safe while still being supported. Furthermore, interviewees described that ideological differences in the goals of policing to protect against crime and chemsex services to reduce harm and support rehabilitation can pose barriers to joint care planning and case management.

Across the work of all partners engaged in harm reduction and support there are challenges in understanding need and measuring impact of services. While Antidote and the HSHS track client progress through their own measures, these measures are not uniformly defined or monitored across support services. The City and Hackney Recovery Service uses the Treatment Outcomes Profile, the nationally mandated outcomes reporting tool for drug and alcohol treatment services; however, interviewees noted that this tool is too generic and does not provide an accurate picture of chemsex-specific treatment outcomes, such as engagement with sexual health services and reduction in high risk sexual activity (88). Interviewees also explained that it is not currently possible to link information on service users who may be supported by multiple service providers at a person-level to evaluate impact of multiple service interventions (4). Furthermore, local and national databases used to monitor substance use treatment and related harms—such as NDTMS, SHRAD, GUMCAD, ELD, LAS, HES, and SafeStats—do not collect or report on data specific to chems use or chemsex-related harm, making it more challenging to monitor impact and inform local and national strategies for service delivery.

Finally, service providers strongly expressed that all health and social care providers working across City and Hackney need training and upskilling to ensure cultural competence (4). These trainings should incorporate information about the social contexts of chemsex and sexualised drug use, appropriate and person-centred terminology, and local harm reduction and support available for people engaged in chemsex. In doing so, professionals must take up responsibility to reduce the stigma of chemsex and stigma of other intersectional communities, including LGBTQIA+ people, sex workers, people living with HIV, and people who use drugs.

5. Conclusions

This needs assessment has used relevant data from available sources, as well as findings from key stakeholder interviews of professionals working in services that provide harm reduction and support for chemsex. While the strength of conclusions is limited based on the lack of robust, accurate local data, the following insights emerge from these findings:

Demographics

1. Provisional estimates for chemsex participation are in the ranges of 845-1,691 for the London Borough of Hackney and 44-88 for the City of London. These figures are based on extrapolations from limited data and therefore there is low confidence in their accuracy.
2. Estimated trends for chemsex participation are severely limited by a lack of high-quality quantitative data. Qualitative evidence from professionals suggests an upward trend in both general chemsex participation and specifically in the use of methamphetamines and GHB.
3. Qualitative evidence suggests that Hackney appears to have a higher concentration of GBMSM and other LGBTQ+ people who engage in chemsex compared to other neighbouring boroughs.
4. The majority of chemsex participants in City and Hackney are likely in the 25-45 age range, white, and identify as cisgender GBMSM. Other LGBTQ+ and gender diverse individuals, as well as people from other ethnic backgrounds, engage in chemsex or other forms of SDU, but may not identify with the term 'chemsex' or feel that chemsex services are appropriate for them.
5. Compared to the general population profile of City and Hackney, white people are overrepresented in services and potentially amongst individuals who engage in chemsex, while Black and Asian people are underrepresented. This may be due to a number of factors, including perceived stigma and beliefs from black and majority ethnic communities that services are catered more to white, cisgender GBMSM and not acceptable to them. This is similar to trends seen in literature.
6. Evidence suggests that people who engage in chemsex in the City and Hackney live in areas with similar levels of deprivation to those who do not engage in chemsex.
7. A small minority of people engaged in chemsex City and Hackney identify as sex workers; however, it is much more likely for individuals who engage in chemsex to engage in sex work compared to the general population of GBMSM.
8. Weak evidence suggests that the majority of chemsex participants in City and Hackney are British, identify as having no religion, are in regular employment and privately renting. These findings are based on a very small sample size from a single source so may inaccurately represent the wider population of people in City and Hackney who engage in chemsex.

Practices

9. Data from local service providers show that methamphetamines and GHB/GBL are the most commonly used drugs by individuals engaged in chemsex support and qualitative evidence from interviews suggests that individuals often use these drugs together, in combination.
10. Individuals also use other drugs, increasingly ketamine, in chemsex settings, either in combination with traditional chemsex drugs or on their own. This speaks to the dynamic nature of drug use within the community of people who engage in chemsex and the need to expand definitions of what constitutes chemsex.
11. Weak evidence suggests that the majority of chemsex service users participate in chemsex on a weekly basis or at least twice a month.
12. There is some evidence to suggest that approximately 4.7% of chemsex participants inject drugs. However, this estimate is drawn from limited local data sources. Based on extrapolated prevalence estimates, this may mean that as many as 150 individuals engage in slamsex in City and Hackney.
13. Limited quantitative evidence suggests that individuals who engage in chemsex show no differences in the frequency of testing for HIV, STIs, and viral hepatitis. While evidence from local service providers show that the majority of individuals engaged in chemsex do not use condoms, there is strong use of PrEP for HIV prevention amongst service users.

Health risks and harms

14. There are large data gaps that prevent from conducting a robust analysis of risks and harms for chemsex at the level of City and Hackney; namely the fact that national data systems capturing health-related harms, like hospitalisations and deaths, do not contain data fields that allow for estimation of chemsex-related events. However, qualitative data from service providers suggests that local harms have increased in the last decade.
15. Qualitative evidence from local stakeholders suggests that information on the respective risk profiles of the three main chems is not sufficiently understood by users.
16. Quantitative evidence suggests that individuals engaged in chemsex in City and Hackney have greater odds of acquiring gonorrhoea compared to those not engaged in chemsex, but do not suggest greater odds of acquiring other STIs, HIV, or viral hepatitis. Evidence from local services show that chemsex may negatively impact individuals' ability to adhere to HIV treatment, if living with HIV. This is consistent with findings in the literature.
17. There is some evidence to suggest that a significant proportion of chemsex participants experience a wide range of unsupported mental health needs, including self-neglect, self-harm, and suicidal ideation. Mental health services are often unable or unwilling to provide appropriate ongoing support for individuals, leading to repeated engagement with crisis services.

Social risks and harms

18. While not all individuals who engage in chemsex will experience social harms, qualitative evidence from stakeholders suggests that individuals who engage in chemsex may face increased risk of harm, such as unemployment and homelessness.
19. There is limited public evidence available on the incidence of chemsex-related crimes in the UK and no evidence on the incidence of chemsex-related crimes in City and Hackney or London.
20. Qualitative evidence suggests that certain types of offending behaviour and opportunistic crime may be associated with engagement in chemsex, including theft, violence without injury, and sexual assault. These are likely under-reported to law enforcement because individuals may fear stigma from law enforcement and punishment from having to disclose their engagement in chemsex and use of drugs.
21. Evidence from previous research and qualitative information suggest that individuals who engage in chemsex may be at increased risk of sexual assault and rape due to inability to set and adhere to personal and sexual boundaries or provide consent while under the influence of chems. Given the dynamic nature of chemsex settings, individuals may be both perpetrators and victims of sexual assault in the same case with the same individuals, which further deters reporting to authorities and makes it challenging for law enforcement to investigate crimes.
22. A small amount of qualitative evidence from historical cases indicate that a subset of people engaged in chemsex may be involved in more serious criminal behaviour and organised crime, including drug trafficking, sexual exploitation, human trafficking, and, in very rare cases, murder. No public data exist on the incidence of these types of crimes within the chemsex community in City and Hackney.

Harm reduction and support services

23. There is a general consensus amongst local professionals and the literature that there are many unmet needs amongst people who engage in chemsex.
24. It is likely that the number of individuals in City and Hackney needing support for chemsex is far greater than the number of individuals currently accessing support. The reasons why individuals may not access support services may be that they believe that their engagement in chemsex is manageable on their own; individuals may not know where to go for support; local services may not have knowledge, expertise, or cultural competence to appropriately support individuals with chemsex; referrals may be closed by services due to non-engagement; and individuals may not be able to engage with services in the way that they are offered (office-based, appointment-only services).

25. It is important that local chemsex support and harm reduction services are led by or in association with trusted LGBTQ+ community groups, as this increases service acceptability and engagement.
26. GBMSM from black and global ethnic majority communities and TGNC individuals who engage in chemsex may be less likely or willing to engage with local support and harm reduction services due to perceived stigma from providers as well as beliefs that local services are more catered to white, cisgender gay men.
27. City and Hackney has a greater number of services that provide tailored harm reduction guidance and support to chemsex compared to other local authorities in London and the UK; however, there is still limited capacity to meet needs, particularly for service users with immediate risks including extreme dependency, chaotic substance use, and co-occurring severe, enduring, and complex mental health needs. Furthermore, quantitative and qualitative data suggest that the need for support is increasing, locally. There is an additional need for culturally competent inpatient detox and residential rehabilitation provision for GBMSM facing withdrawal from GHB/GBL.
28. Differences in commissioning structures and geographic eligibility have created barriers for GBMSM to receive holistic and coordinated support from mental health, sexual health, and substance use services. Mental health services' requirements of abstinence from substances or 'controlled use' is a particular barrier to ensuring GBMSM can receive support for trauma, suicidal ideation, and drug-induced psychosis, both brought about and exacerbated through chemsex.
29. GBMSM who are engaging in chemsex support services have increasingly complex social support needs around housing, criminal justice involvement, domestic abuse, unemployment, and personal debt. Frontline support and other professionals working in mental health, sexual health, physical health, social care, housing and benefits, domestic violence, employment, and law enforcement services need to be upskilled in the behaviours, risks, and presentations of individuals engaged in chemsex; how to coordinate holistic support; and how to support individuals in a non-stigmatising manner.
30. Professionals noted the need for enhanced community-based harm reduction, including outreach through geosocial networking apps and nightlife venues, point-in-time education and advice in chemsex settings, and chemsex-specific needle and syringe provision and safer chems use paraphernalia.

Data

31. There are large gaps in data that make it difficult to appropriately capture the prevalence of chemsex and incidence of chemsex-related harm. Most health and social care service datasets do not have data fields that record chemsex-related activity or any suitable proxy measures. Additionally, there are significant uncertainties in data provided by chemsex support services due to lack of ability to match service-level data, differences in units used across different services (person-level data vs. encounter-level data), and lack of uniform

measures. Therefore qualitative and quantitative estimates of the prevalence, demographics, risks, harms, or needs of individuals may be biased to the specific cohort of individuals engaged in support services.

32. Current research and qualitative information from local services lack information on specific support needs of other LGBTQ+ subgroups who engage in sexualised drug use, including trans women, nonbinary individuals, and migrants. Local research should focus on how best to engage and support these groups of individuals with their needs through current and future service provision.

6. Recommendations

The following recommendations build on the conclusions in this needs assessment. The recommendations have not been prioritised and it is anticipated that this will be done through the ongoing work of the City and Hackney CDP and Sexual Health Forum.

Policy and programming

Recommendation 1: Adopt a holistic service approach with increased support for complex mental health needs such as psychosis and trauma

Detail

Chemsex service models should integrate the multifaceted aspects of chemsex into one easy-to-access place, in order to best support chemsex participants. Services should involve sexual health, substance use, and mental health professionals, along with support to address wider social needs such as housing, finances, and domestic abuse support services. The service should be embedded into wider LGBT+ services, where the focus is on supporting the global needs of the individual, not just the narrow aspect of their substance use.

Justification

Chemsex is a complex problem involving multiple different professions and services to adequately address. Professionals unanimously agree that current models cause a breakdown in progress and engagement by taking a siloed approach. There are often delays at the junctions between siloed services where chemsex participants are left in 'limbo' without support. Chemsex participants also do not always receive the support they need if the service to which they present may only focus on one aspect of their challenges, which can lead to worsening substance use and disillusionment with the benefit of service engagement. In particular, individuals engaged in chemsex often experience complex, severe, and enduring mental health challenges that go unaddressed and influence and exacerbate other support needs.

Recommendation 2: Explore cross-sector commissioning opportunities between substance use, sexual health, and mental health

Detail

To achieve recommendation 1, commissioning decisions for chemsex services should recognise the complex, interwoven nature of the problem and funding streams should be collated in this area to provide the means to form collaborative holistic services for chemsex. Current silos in commissioning of substance use, sexual health, and mental health services between local authorities and ICBs across different geographies with different eligibility requirements and monitoring frameworks make it difficult to adequately integrate or coordinate service delivery for individuals.

Justification

By recognising the integrated approach services must take to address the underlying needs and reflecting this in the commissioning stage, chemsex services across different organisations would be incentivised to work together better to address both the root causes for ongoing problematic substance use and the health and social needs individuals face as part of their engagement in chemsex. This would also move the onus of remit attribution from the day to day work of front-line staff to the commissioning stage, freeing staff to provide flexible services that meet the needs of the population.

Recommendation 3: Improve accessibility and acceptability of services for black and global majority ethnic communities and transgender and gender nonconforming individuals

Detail

Existing chemsex-specific and drug and alcohol services should build partnerships with organisations and community leaders that represent LGBTQ+ black and global majority ethnic communities to build greater trust and support within these communities. Additionally, chemsex services should work with community leaders to review all promotional materials and materials used in services to avoid potential unintentional stigmatising or non-inclusive language and include explicit messages of inclusivity for black and global majority ethnic communities and transgender and gender nonconforming individuals.

Justification

As noted by professionals, people who engage in practices similar to chemsex may have mixed perceptions of the term. In particular, GBMSM from black and global majority ethnic communities and transgender and gender nonconforming individuals may view chemsex, and thus services that brand themselves as 'chemsex-specific', as catering predominantly to white, cisgender gay men. Drug and alcohol services, and LGBT+ services in general have traditionally been perceived by these minoritised communities as inaccessible and unacceptable because they may not understand or represent the intersectional stigmas that these communities experience related to their use of chems.

Recommendation 4: Strengthen referral pathways between disparate providers

Detail

Adopting a holistic service approach will take significant time and coordination. In the meantime, the current referral pathways, availability of services and eligibility criteria need to be clarified at the borough level. Existing service managers should collaborate to form a single agreed flow for service users through the various system services, with a well defined direction of travel and clear criteria for transition between services. This should be published between the services and made available to front-line professionals to provide clarity on where and when to direct service users.

Justification

Currently, there are frequent delays caused by a lack of clarity over the appropriate service order and it is not uncommon for a client to not be able to access mental health support because of their ongoing substance use, while not being able to progress with their substance use support because of their unaddressed mental health needs. This not only causes significant delays in management but also means the service users' needs are left unaddressed, leaving them highly vulnerable. A clear, mutually agreed referral pathway between services would not only alleviate these issues but also reduce administrative burden for front-line staff.

Recommendation 5: Explore pan-London partnerships to coordinate response

Detail

Given the highly mobile and widespread nature of chemsex, active and frequent collaboration between service providers, local authorities and other stakeholders should be encouraged, as pan-London partnerships and services will help achieve economies of scale in responding to public health concerns related to chemsex. These partnerships should involve data sharing,

community engagement, coordinated responses to regional circumstances, and joint commissioning of providers, where appropriate.

Justification

Chemsex participation does not abide by borough boundaries and open access sexual health services often result in chemsex participants using services geographically distant to their home address. This can be a client-led strategy to help them cope with the inherent stigma of chemsex and thus should be maintained to ensure chemsex participants continue to engage with services. This does, however, make it more difficult to coordinate with the borough-bound services when there is significant variation in approaches across boroughs. Collaboration and coordination across London would not only help to keep all parties informed of up-to-date evidence around chemsex, but would also foster opportunities for pan-London collaboration on aspects of chemsex which lend themselves to coordinated approaches.

Recommendation 6: Train front-line staff in ambulance services, accident and emergency, secondary mental health services, homelessness, law enforcement, social care, drug and alcohol services, and sexual health on chemsex awareness, response, and cultural competence

Detail

Training sessions on chemsex awareness and cultural competence should be held for front line staff across services. These should include improving understanding of what chemsex is, the types of drugs involved, the vocabulary used in chemsex, the types of sexual practice involved, and the associated psychological and mental health complexities. These training sessions should include staff from substance use, sexual health, mental health, primary care, ambulance, social care, homelessness, hospital, and A&E services.

Justification

Chemsex participants may present to any of the listed services initially and the response they receive from staff at that initial presentation can have a significant impact on whether they continue to seek support. Professionals agree that service users alienated by a poorly handled, culturally insensitive interaction are significantly less likely to receive the support they need and one of the driving reasons for chemsex participants not engaging in services is the perception that services as 'not meant for them' or 'do not understand chemsex'. Cross-service coverage is important as it creates opportunities to direct service users to the right service to meet their needs regardless of where they present.

Recommendation 7: Increase outreach on sex and dating platforms and in nightlife venues

Detail

Chemsex services should contain an element of digital outreach on geosocial networking apps and physical outreach in nightlife spaces where individuals may frequent before attending chemsex parties ('chillouts'). This should include service advertisement, along with opportunistic engagement and to advise on point-in-time harm reduction and bring people into support services.

Justification

The vast majority of modern chemsex activity is facilitated by geosocial networking apps or in nightlife venues where individuals may meet others to organise chemsex parties ('chillouts') after. Services need to reach chemsex participants where they are to raise awareness of the risks and harms of chemsex, provide impactful harm reduction materials and information, and support access to treatment services for those who may want to engage.

Recommendation 8: Increase knowledge and awareness of the risks of chems use, specifically GHB overdose, methamphetamine-induced psychosis, and sexual assault

Detail

Priority should be placed on disseminating accurate information on safer chems use as well as the risks and harms of chemsex. Interviewed professionals noted particular need to educate users on the risks of GHB/GBL overdose, methamphetamine-induced psychosis, and potential sexual assault and exploitation. Accurate targeted information should be presented at all opportunities, including service attendance, digital outreach and community-based harm reduction interventions. Information and education relating to chems should also be incorporated into existing training nightlife programmes, such as [Hackney Nights](#), and delivered by trusted and knowledgeable community organisations so that venues are equipped and incentivised to support people experiencing harm from chems use. Both venue staff and security teams should be trained on an ongoing basis to ensure they are up-to-date on relevant knowledge and skills.

Justification

Professionals report rising harms experienced by naive and regular chems users, particularly in relation to GHB/GBL and methamphetamine. Professionals in criminal justice services also report that there is lack of awareness around the inherent risks of GHB/GBL and opportunistic

crime in particular, resulting in individuals coming to harm from overdose, dependence, and malicious intent. It is common for individuals to attend nightlife venues and then later attend chemsex parties ('chillouts') with individuals that they may meet in nightlife spaces. Some people may also engage in chemsex in sex-on-premises venues; as such, nightlife and sex-on-premises venues are a key setting in which staff are able to promote harm reduction and ensure safety of their patrons.

Recommendation 9: Develop and expand community-based harm reduction and risk management interventions

Harm reduction interventions, such as bespoke chemsex paraphernalia and informational materials, should be actively distributed to people who engage in chemsex, including information on safer drug dosing, sexual health resources, and consent and darkroom etiquette. Harm reduction interventions should also seek to improve social care and connections amongst people who engage in chemsex and reduce factors that contribute to increased harm within chemsex contexts, such as lack of trust and agency. These interventions should be led by people who engage in chemsex and be integrated into spaces where chemsex occurs, as well as associated spaces, such as queer nightlife venues, sex-on-premises venues, and online hook up apps.

Justification

Engagement in chemsex may be associated with transmission of STIs and BBVs, worsening mental health, acute psychosis, and dependence and overdose. Harm reduction interventions provide a means to reduce these risks, particularly for individuals who may not want to engage in more structured treatment, and also help navigate individuals to engage in structured treatment. Given the intersectional stigma that people who engage in chemsex experience—including homophobia, racism, HIV stigma, transphobia, and stigma of drug use—it is crucial that harm reduction interventions be led by individuals in the community and chemsex settings can provide ideal opportunities for engagement.

Data collection

Recommendation 1: Increase local knowledge through community engagement and research

Detail

City and Hackney Public Health should engage local chemsex participants through trusted community organisations to improve understanding on barriers to service use and unmet needs.

This should include a variety of engagement methodologies, including focus groups, surveys and community engagement events.

Justification

There are significant gaps in both data collection and professional understanding around chemsex. Direct community engagement would help to fill quantitative data gaps at the local level, as well as ensure service arrangements meet community needs and are appropriately aligned. However, given potential ethical concerns and unwillingness of local chemsex participants to speak with local authority officers about their chemsex practice, it is more appropriate that trusted organisations be funded to conduct this engagement and research with appropriate ethical oversight.

Recommendation 2: Improve data collection amongst local service

Detail

Local services should be encouraged to collate accurate service-level data through a review and auditing process. Data should include number of service users, referral route, substances used, route of administration, frequency of use, STI exposure, HIV status, HCV status, mental health status, suicidal ideation, and exposure to other social harms related to chems use.

Justification

This will aid internal service review to identify trends of concern as well as provide evidence of need which in turn would enable higher quality commissioning and system level decisions. Pan-London data sharing would also enable teams across boroughs to learn from each other's experiences in this complex area and encourage the identification and use of best practices.

Recommendation 3: Revise triage questions in the online STI kit order service to improve data collection

Detail

The current triage questions on the SHL ordering form should be modified to improve clarity and data collection. Given the relevance of chemsex and sexualised drug use for assessing sexual health risk, the triage questionnaire should include one question specifically asking participants if they engaged in sexualised drug use or chemsex, with an attached definition.

Justification

The SHL database is currently the most complete data set that Public Health has access to on STI and BBV testing amongst GBMSM who engage in chemsex. Improvement in the questions asked would allow for high quality data analysis that could improve understanding of local-level chemsex participation and in turn, improve services. The current formation of the chemsex-related question posed to its users are open to misinterpretation and they obscure and conflate activities such that researchers cannot perform deeper analysis to gain conclusive insights from the data.

Recommendation 4: Develop chemsex-specific fields for relevant local, regional, and national databases

Detail

National clinical associations in tandem with community organisations representing people who engage in chemsex should work together with database administrators and governmental bodies to develop chemsex-specific fields for all relevant databases. These should include specific data points on the frequency of sexualised use of methamphetamine, GHB/GBL and mephedrone, as well as admissions and clinical encounters with chemsex as a primary or secondary cause. Data fields should capture the range of chemsex activity, including: specific drug overdose (i.e. GHB/GBL overdose, not generic drug overdose), encounters due to chemsex (i.e. Sexual health visit due to potential HIV exposure at chemsex party) and admission as a consequence of chemsex activity (i.e. mental and behavioural disorder related to methamphetamine use in sexual context). Target databases include: NDTMS, SHRAD, GUMCAD, ELD, LAS, HES, A&E admissions.

Justification

Databases do not currently record chemsex-specific information at any level, making quantitative analysis of chemsex impossible. There is currently no high quality quantitative data available at any level of data gathering. Data gaps include:

- No record of chemsex-related presentation to GP on ELD
- No record of substance specific overdose at A&E or LAS
- No record of chemsex-related admissions to hospitals on HES
- No record of methamphetamine, GHB/GBL or mephedrone on NDTMS
- No record of specific chemsex activity or sexualised drug use on SHRAD
- No record of chemsex-related crime or law enforcement encounters on SafeStats
- No record of chemsex-specific mortality on any database

These data are vital to appropriately assess the needs of this population and guide service provision as required and has been previously recommended by the Central Government (89).

References

1. Stuart D. Chemsex: origins of the word, a history of the phenomenon and a respect to the culture. *Drugs Alcohol Today*. 2019;19(1):3–10.
2. Maxwell S, Shahmanesh M, Gafos M. Chemsex behaviours among men who have sex with men: A systematic review of the literature. *Int J Drug Policy*. 2019 Jan;63:74–89.
3. Edmundson C, Heinsbroek E, Glass R, Hope V, Mohammed H, White M, et al. Sexualised drug use in the United Kingdom (UK): A review of the literature. *Int J Drug Policy*. 2018 May;55:131–48.
4. Blissett A. Thematic Analysis of Chemsex Professionals Semi-structured Interviews [Internet]. Blissett A, editor. 2023-2024. Available from: [N/A](#)
5. Coronado-Muñoz M, García-Cabrera E, Quintero-Flórez A, Román E, Vilches-Arenas Á. Sexualized drug use and chemsex among men who have sex with men in Europe: A systematic review and meta-analysis. *J Clin Med*. 2024 Mar 21;13(6):1812.
6. Amundsen E, Muller AE, Reierth E, Skogen V, Berg RC. Chemsex Among Men Who Have Sex With Men: A Systematic Scoping Review of Research Methods. *J Homosex*. 2024 May 11;71(6):1392–418.
7. Pufall EL, Kall M, Shahmanesh M, Nardone A, Gilson R, Delpech V, et al. Sexualized drug use ('chemsex') and high-risk sexual behaviours in HIV-positive men who have sex with men. *HIV Med*. 2018 Apr;19(4):261–70.
8. Íncera-Fernández D, Román FJ, Gámez-Guadix M. Risky sexual practices, sexually transmitted infections, motivations, and mental health among heterosexual women and men who practice sexualized drug use in Spain. *Int J Environ Res Public Health*. 2022 May 24;19(11):6387.
9. Weatherburn P, Hickson F, Reid D, Torres-Rueda S, Bourne A. Motivations and values associated with combining sex and illicit drugs ('chemsex') among gay men in South London: findings from a qualitative study. *Sex Transm Infect*. 2017 May;93(3):203–6.
10. Kurtz SP. Post-circuit blues: motivations and consequences of crystal meth use among gay men in Miami. *AIDS Behav*. 2005 Mar;9(1):63–72.
11. Hawkinson DE, Witzel TC, Gafos M. Exploring practices to enhance benefits and reduce risks of chemsex among gay, bisexual, and other men who have sex with men: A meta-ethnography. *Int J Drug Policy*. 2024 May;127(104398):104398.
12. Brooks-Gordon B, Ebbitt E. The chemsex "consent ladder" in male sex work: Perspectives of health providers on derailment and empowerment. *Soc Sci (Basel)*. 2021 Feb 10;10(2):69.
13. Bourne A, Reid D, Hickson F, Torres-Rueda S, Steinberg P, Weatherburn P. "Chemsex" and harm reduction need among gay men in South London. *Int J Drug Policy*. 2015 Dec;26(12):1171–6.
14. Lourenco D. NBC News. 2018 [cited 2026 Feb 5]. Sex and drugs: Popular gay dating app allows

users to find more than a date. Available from:

<https://www.nbcnews.com/feature/nbc-out/sex-drugs-popular-gay-dating-app-allows-users-find-more-n896081>

15. Pollard A, Nadarzynski T, Llewellyn C. Syndemics of stigma, minority-stress, maladaptive coping, risk environments and littoral spaces among men who have sex with men using chemsex. *Cult Health Sex*. 2018 Apr;20(4):411–27.
16. Tan RKJ, Phua K, Tan A, Gan DCJ, Ho LPP, Ong EJ, et al. Exploring the role of trauma in underpinning sexualised drug use ('chemsex') among gay, bisexual and other men who have sex with men in Singapore. *Int J Drug Policy*. 2021 Nov;97(103333):103333.
17. McGaughey G, Richardson D, Vera J. Harm reduction services for people engaging in chemsex in Brighton, UK: A pilot qualitative study. *Int J STD AIDS*. 2023 Nov;34(13):940–4.
18. Clarke L, Holt P, Ward C. Oo4 Safeguarding risks in chemsex participants requiring a multidisciplinary approach. *Sex Transm Infect*. 2023 Jun 1;99(Suppl 1):A2–A2.
19. Javaid A. The interconnectedness of chemsex, drugs, sexual promiscuity and sexual violence. *Ir J Sociol*. 2018 Aug;26(2):183–207.
20. Carthy E, Hillier B, Tracy DK, Pakianathan M, Morris S, Shell Y, et al. Chemsex-related crime and vulnerability: A public health and criminal justice priority. *Med Sci Law*. 2021 Oct;61(4):247–9.
21. Shell Y. HMPPS study on chemsex and crime. 2022.
22. Dolengevich-Segal H, Rodríguez-Salgado B, Gómez-Arnau J, Sánchez-Mateos D. Severe psychosis, drug dependence, and hepatitis C related to slamming mephedrone. *Case Rep Psychiatry*. 2016 May 10;2016:8379562.
23. Íncera-Fernández D, Gámez-Guadix M, Moreno-Guillén S. Mental health symptoms associated with sexualized drug use (chemsex) among men who have sex with men: A systematic review. *Int J Environ Res Public Health*. 2021 Dec 17;18(24):13299.
24. Public Health England. Substance misuse services for men who have sex with men involved in chemsex. Public Health England; 2015 Jan.
25. All-cause and cause-specific mortality by sexual orientation, England and Wales - Office for National Statistics [Internet]. Office for National Statistics; 2026 [cited 2026 May 21]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/allcauseandcausespecificmortalitybysexualorientationenglandandwales/march2021tonovember2024>
26. BBC News. Stephen Port: Serial killer guilty of murdering four men. BBC [Internet]. 2016 Nov 23 [cited 2026 Feb 5]; Available from: <https://www.bbc.co.uk/news/uk-england-38077859>
27. Azhar M. Chemsex: Hidden Pleasures, Hidden Harms. BBC [Internet]. 2025 Nov 5 [cited 2026 Feb 9]; Available from: <https://www.bbc.co.uk/programmes/m002ln42>
28. Leader S. ITV News. 2025 [cited 2026 Feb 9]. A "silent crisis": "Chemsex" related drugs claiming LGBT+ lives, yet few are taking notice. Available from: <https://www.itv.com/news/2025-03-11/a-silent-crisis-chemsex-drugs-claiming-lgbt-lives-yet>

[-few-are-listening](#)

29. BBC. BBC. 2021 [cited 2024 Mar]. Stephen Port: Serial killer was “obsessed” with drug rape. Available from: <https://www.bbc.co.uk/news/uk-england-london-58800989>
30. His Majesty's Inspectorate of Constabulary and Fire & Rescue Services [Internet]. 2023 [cited 2026 Feb 6]. An inspection of the Metropolitan Police Service's response to lessons from the Stephen Port murders. Available from: <https://hmicfrs.justiceinspectors.gov.uk/publication-html/inspection-of-the-metropolitan-police-services-response-to-lessons-from-the-stephen-port-murders/>
31. BBC. BBC. 2020 [cited 2024 Mar]. Reynhard Sinaga: Serial rapist “abused 206 men.” Available from: <https://www.bbc.co.uk/news/uk-england-manchester-55276209>
32. Davis A. College of Policing. 2024 [cited 2026 Feb 6]. Chemsex-related crime. Available from: <https://www.college.police.uk/article/chemsex-related-crime>
33. From harm to hope: a 10-year drugs plan to cut crime and save lives [Internet]. HM Government; 2021. Available from: https://assets.publishing.service.gov.uk/media/629078bad3bf7f036fc492d1/From_harm_to_hope_PDF.pdf
34. From harm to hope: a 10-year drugs plan to cut crime and save lives - first annual report 2022-23 [Internet]. HM Government; 2023. Available from: https://assets.publishing.service.gov.uk/media/65dc7655529bfa0011e95508/E02949325_15.1_09_HO_Harm_to_Hope_AR_2022-23_Web+Accessible_v02.pdf
35. Home Office. From Harm to Hope: Guidance for local delivery partners. HM Government; 2022 Jun.
36. Positive Voices 2022: survey report [Internet]. UK Health Security Agency; 2024 Jan [cited 2026 Feb 6]. Available from: <https://www.gov.uk/government/publications/hiv-positive-voices-survey/positive-voices-2022-survey-report>
37. HIV action plan for England, 2025 to 2030 [Internet]. Department of Health and Social Care; 2025 Dec [cited 2026 Feb 5]. Available from: <https://www.gov.uk/government/publications/hiv-action-plan-for-england-2025-to-2030/hiv-action-plan-for-england-2025-to-2030>
38. City & Hackney Public Health. DPH Annual Report 2019/20: Substance misuse in the City of London and Hackney. City & Hackney Public Health; 2019.
39. City and Hackney Public Health. Substance misuse: Joint strategic needs assessment [Internet]. Palgrave Macmillan; 2019. Available from: <http://dx.doi.org/10.1057/9781137359803.0017>
40. City and Hackney Public Health Team. City and Hackney sexual and reproductive health strategy 2024-2029 [Internet]. 2024 Mar. Available from: <https://cityhackneyhealth.org.uk/wp-content/uploads/2025/01/City-Hackney-Sexual-and-Reproductive-Health-Strategy-2024-2029.pdf>
41. Baldry G, Habib Meriggi G, Mullen D, Corkin H, Andrews A, Lowndes CM, et al.

Chemsex-associated drug use amongst men and gender-diverse people having sex with men in the UK: Findings from an online community survey, 2024. *Int J STD AIDS*. 2026 Apr 28;9564624261448075.

42. Roskams M. Sexual orientation, England and Wales - Office for National Statistics [Internet]. Office for National Statistics; 2023 [cited 2026 Feb 9]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualorientationenglandandwales/census2021>
43. Preventx. Sexual Health London (SHL) [Internet]. Available from: <https://www.shl.uk/>
44. Revez A, Hilton S, Edwards T, Vosper J. High risk sex & chemsex service annual report, 2024-2025. Homerton Healthcare NHS Foundation Trust; 2025 Sep.
45. Moncrieff M. Antidote Service User Report - Hackney and City of London 2023/24. Antidote - London Friend; 2024 Apr.
46. Hackney Council. Population data. [cited 2026 Feb 5]. Census data release from the Office of National Statistics (ONS) - Sexual Orientation and Gender Identity (SOGI). Available from: <https://docs.google.com/document/d/1PpREjvCo7dwclc6SSSfjqjJokwxiJUov1D3Q3-qgZI/edit>
47. Ministry of Housing, Communities, Local Government (2018 to 2021). English indices of deprivation 2019 [Internet]. GOV.UK; 2019 [cited 2026 Feb 20]. Available from: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>
48. Bohn A, Sander D, Köhler T, Hees N, Oswald F, Scherbaum N, et al. Chemsex and mental health of men who have sex with men in Germany. *Front Psychiatry*. 2020 Nov 4;11:542301.
49. Santoro P, Rodríguez R, Morales P, Morano A, Morán M. One "chemsex" or many? Types of chemsex sessions among gay and other men who have sex with men in Madrid, Spain: findings from a qualitative study. *Int J Drug Policy*. 2020 Aug;82(102790):102790.
50. Drug Combinations "Mixing Drugs" - Drug and Alcohol Information and Support in Ireland - Drugs.ie [Internet]. [cited 2026 Feb 10]. Available from: https://www.drugs.ie/drugs_info/about_drugs/poly_drug_use1/
51. Escubedo E, Camarasa J, Chipana C, García-Ratés S, Pubill D. Involvement of nicotinic receptors in methamphetamine- and MDMA-induced neurotoxicity: pharmacological implications. *Int Rev Neurobiol*. 2009;88:121-66.
52. Der-Ghazarian TS, Charmchi D, Noudali SN, Scott SN, Holter MC, Newbern JM, et al. Neural Circuits Associated with 5-HT1B Receptor Agonist Inhibition of Methamphetamine Seeking in the Conditioned Place Preference Model. *ACS Chem Neurosci*. 2019 Jul 17;10(7):3271-83.
53. Tunnicliff G. Sites of action of gamma-hydroxybutyrate (GHB)--a neuroactive drug with abuse potential. *J Toxicol Clin Toxicol*. 1997;35(6):581-90.
54. Busardò FP, Jones AW. GHB pharmacology and toxicology: acute intoxication, concentrations in blood and urine in forensic cases and treatment of the withdrawal syndrome. *Curr Neuropharmacol*. 2015 Jan;13(1):47-70.
55. Wong CGT, Chan KFY, Gibson KM, Snead OC. Gamma-hydroxybutyric acid: neurobiology and

toxicology of a recreational drug. *Toxicol Rev.* 2004;23(1):3–20.

56. Dufayet L, Bargel S, Bonnet A, Boukerma AK, Chevallier C, Evrard M, et al. Gamma-hydroxybutyrate (GHB), 1,4-butanediol (1,4BD), and gamma-butyrolactone (GBL) intoxication: A state-of-the-art review. *Regul Toxicol Pharmacol.* 2023 Aug;142:105435.
57. Gregg RA, Baumann MH, Partilla JS, Bonano JS, Vouga A, Tallarida CS, et al. Stereochemistry of mephedrone neuropharmacology: enantiomer-specific behavioural and neurochemical effects in rats. *Br J Pharmacol.* 2015 Feb;172(3):883–94.
58. Pantano F, Tittarelli R, Mannocchi G, Pacifici R, di Luca A, Busardò FP, et al. Neurotoxicity Induced by Mephedrone: An up-to-date Review. *Curr Neuropharmacol.* 2017;15(5):738–49.
59. Chessell C, Rabuszko L, Richardson D, Llewellyn C. Factors associated with the sexual transmission of *Strongyloides stercoralis* in men who have sex with men: A systematic review. *J Eur Acad Dermatol Venereol.* 2024 Apr;38(4):673–9.
60. Strong C, Huang P, Li CW, Ku SWW, Wu HJ, Bourne A. HIV, chemsex, and the need for harm-reduction interventions to support gay, bisexual, and other men who have sex with men. *Lancet HIV.* 2022 Oct;9(10):e717–25.
61. Flores Anato JL, Panagiotoglou D, Greenwald ZR, Blanchette M, Trottier C, Vaziri M, et al. Chemsex and incidence of sexually transmitted infections among Canadian pre-exposure prophylaxis (PrEP) users in the l'Actuel PrEP Cohort (2013–2020). *Sex Transm Infect.* 2022 Dec;98(8):549–56.
62. Hanum N, Cambiano V, Sewell J, Rodger AJ, Nwokolo N, Asboe D, et al. Trends in HIV incidence between 2013–2019 and association of baseline factors with subsequent incident HIV among gay, bisexual, and other men who have sex with men attending sexual health clinics in England: A prospective cohort study. *PLoS Med.* 2021 Jun;18(6):e1003677.
63. Howarth AR, Apea V, Michie S, Morris S, Sachikonye M, Mercer CH, et al. The association between use of chemsex drugs and HIV clinic attendance among gay and bisexual men living with HIV in London. *HIV Med.* 2021 Sep;22(8):641–9.
64. Adler Z, Fitzpatrick C, Broadwell N, Churchill D, Richardson D. Chemsex and antiretroviral prescribing in an HIV cohort in Brighton, UK. *HIV Med.* 2022 Aug;23(7):797–800.
65. Glynn RW, Byrne N, O'Dea S, Shanley A, Codd M, Keenan E, et al. Chemsex, risk behaviours and sexually transmitted infections among men who have sex with men in Dublin, Ireland. *Int J Drug Policy.* 2018 Feb;52:9–15.
66. Jongen VW, Van Der Loeff MFS, Van Den Elshout M, Wijstma E, Coyer L, Davidovich U, et al. Bacterial sexually transmitted infections are concentrated in subpopulations of men who have sex with men using HIV pre-exposure prophylaxis. *AIDS.* 2023 Nov 1;37(13):2059–68.
67. MacGregor L, Kohli M, Looker KJ, Hickson F, Weatherburn P, Schmidt AJ, et al. Chemsex and diagnoses of syphilis, gonorrhoea and chlamydia among men who have sex with men in the UK: a multivariable prediction model using causal inference methodology. *Sex Transm Infect.* 2021 Jun;97(4):282–9.
68. Blomquist PB, Mohammed H, Mikhail A, Weatherburn P, Reid D, Wayal S, et al. Characteristics and sexual health service use of MSM engaging in chemsex: results from a large online survey

- in England. *Sex Transm Infect.* 2020 Dec;96(8):590–5.
69. Chan DPC, Sun HY, Wong HTH, Lee SS, Hung CC. Sexually acquired hepatitis C virus infection: a review. *Int J Infect Dis.* 2016 Aug;49:47–58.
 70. Harris M. An urgent impetus for action: safe inhalation interventions to reduce COVID-19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom. *Int J Drug Policy.* 2020 Sep;83(102829):102829.
 71. Tsai H, Lee J, Hedlin H, Zamanian RT, de Jesus Perez VA. Methamphetamine use association with pulmonary diseases: a retrospective investigation of hospital discharges in California from 2005 to 2011. *ERJ Open Res.* 2019 Oct 15;5(4):00017–2019.
 72. GOV.UK [Internet]. [cited 2026 Feb 5]. Shooting Up: infections and other injecting-related harms among people who inject drugs in the UK, data to end of 2021. Available from: <https://www.gov.uk/government/publications/shooting-up-infections-among-people-who-inject-drugs-in-the-uk/shooting-up-infections-and-other-injecting-related-harms-among-people-who-inject-drugs-in-the-uk-data-to-end-of-2021>
 73. Strasser M, Halms T, Rütther T, Hasan A, Gertzen M. Lethal lust: Suicidal behavior and chemsex-A narrative review of the literature. *Brain Sci.* 2023 Jan 20;13(2):174.
 74. Moreno-Gámez L, Hernández-Huerta D, Lahera G. Chemsex and psychosis: A systematic review. *Behav Sci (Basel).* 2022 Dec 15;12(12):516.
 75. Brunt TM, Graf N, Deimel D, Schecke H, van Amsterdam J, Knoop L, et al. Mental health among men who have sex with men under the influence of psychoactive substances: A systematic review. *Int J Ment Health Addict.* 2025 Jun;23(3):2289–313.
 76. Tay E, Lo WKW, Murnion B. Current insights on the impact of gamma-hydroxybutyrate (GHB) abuse. *Subst Abuse Rehabil.* 2022 Feb 9;13:13–23.
 77. Number of self-poisonings where Gamma-hydroxybutyrate (GHB) was mentioned on the death certificate, England and Wales and London, deaths registered between 2001 and 2018 [Internet]. Office for National Statistics; 2019 [cited 2026 Feb 5]. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/10788numberofselfpoisoningswhereregammahydroxybutyrateghbwasmentionedonthedeathcertificateenglandandwalesandlondondeathsregisteredbetween2001and2018>
 78. Walsh H. BBC News. 2025 [cited 2026 Feb 10]. Chemsex: London man says his life was “slowly deteriorating.” Available from: <https://www.bbc.co.uk/news/articles/c4gx19vvnjlo>
 79. Mueller AK, Leifheit KM, Tilchin C, Wagner J, Schumacher CM, Thornton N, et al. Homelessness and the association with future substance use and STI/HIV risk behaviors among urban gay, bisexual, and other men who have sex with men (MSM): a longitudinal analysis. *J Soc Distress Homeless.* 2024 Jul 2;33(2):403–12.
 80. Dickson-Gomez J, Krechel S, Ohlrich J, Hernandez-Meier J, Kostelac C. “They won't prosecute, but they will though:” the continuing struggle between criminalization and harm reduction within the criminal justice system in the context of an opioid overdose crisis. *Harm Reduct J.* 2025 Aug 22;22(1):145.
 81. L'Yavanc T, Gosset D, Plathey M, Jedrzejewski T, Gazalet P, Lasry S, et al. Is There a Reduction in

- Chemsex Practice in Men Who Have Sex With Men During COVID-19 Lockdown? Results of the CheRRLock Study. *J Acquir Immune Defic Syndr*. 2023 Apr 15;92(5):378–84.
82. Smiles C, O'Donnell A, Jackson K. Needle exchange practitioners accounts of delivering harm reduction advice for chemsex: implications for policy and practice. *Drugs (Abingdon Engl)*. 2022 Jan 19;30(3):1–9.
 83. Lobo Antuña V, Lobo Antuña M, Fernández Soro A, Climent B. Screening and Decolonization Programs for *Staphylococcus aureus* Carriers in the Slamming-Practice Community: A New Strategy for Harm Reduction?: Report of a Clinical Case. *Infect Dis Clin Pract* . 2024 Mar;32(2):1.
 84. Campbell T, Gurreri N, Margetts A, Mundy E, Rutter S. Developing chemsex intervention services: Guidance for psychological care provision [Internet]. Leicester, England: British Psychological Society; 2023. Available from: <https://doi.org/10.53841/bpsrep.2023.bre59>
 85. Gaudette Y, Flores-Aranda J, Heisbourg E. Needs and experiences of people practising chemsex with support services: toward chemsex-affirmative interventions. *J Mens Health*. 2022;18(12):57–67.
 86. Hammond R, Cambiano V, Lampe FC, Asboe D, Clarke A, Gilson R, et al. Predictors of starting and stopping chemsex in men who have sex with men in England: findings from the AURAH2 prospective study. *Sex Transm Infect*. 2023 Nov;99(7):474–81.
 87. Banbury S, Lusher J, Chandler C, Zervoulis K. A pilot RCT of an online mindfulness-based cognitive intervention for chemsex. *Couns Psychother Res*. 2024 Sep;24(3):994–1005.
 88. Office of Health Improvement and Disparities. Adult Treatment Outcomes Profile (TOP) [Internet]. National Drug Treatment Monitoring System (NDTMS); Available from: <https://www.ndtms.net/resources/public/Event%20and%20Training%20Documentation/CDSQ%20combined%20review%20and%20outcome%20forms/Adult%20secure%20estate%20TOP%20form%20CDSQ%20v1.pdf>
 89. GOV.UK [Internet]. [cited 2026 Feb 5]. Letter from the minister of state for crime, policing and probation to the chair of the advisory council on the misuse of drugs (accessible version). Available from: <https://www.gov.uk/government/publications/response-to-the-acmd-on-ghb-gbl-and-close-ly-related-compounds/letter-from-the-minister-of-state-for-crime-policing-and-probation-to-the-chair-of-the-advisory-council-on-the-misuse-of-drugs-accessible-version>

Appendix 1: Literature review search terms

Table 9. Search terms for literature review undertaken by Public Health.

Search	Terms	Results
1	"chemsex".ti,ab,kw,kf.	1607
2	limit 1 to yr="2019 -Current"	1210
3	limit 2 to "systematic review" [Limit not valid in Journals@Ovid,Your Journals@Ovid,AMED,HMIC; records were retained]	164
4	remove duplicates from 3	130

Appendix 2: Sensitivity analysis of SHL data

Data from SHL, the online STI testing kit platform, includes information on all unique service users between 2022-2024 for each year that the individual uses the service. Some of the characteristics of each user changes from year to year, such as age group or whether or not they engage in sex while under the influence. Table 10 shows how many unique service users have multiple different values for each characteristic across the three years of data.

Table 10. The number of unique SHL service users double counted in each descriptive characteristic in SHL data.

Characteristic	Number of Unique Service Users
Age	486
Engaged sex while under the influence	748
Engaged in sex work	193
Engaged in IVDU	82
Ethnic group	2
Gender	15
Gender of sexual partners	167
IMD	282
Local authority of residence	15

Source: Preventx. SHL users from City of London and Hackney, 2022-2024. 2025.

This is important because it has the potential to produce inaccurate estimates. When estimating the proportion of total service users who engaged in sex while under the influence of drugs or alcohol, service users may appear in both groups (service users who have sex while under the influence vs. service users who do not have sex while under the influence) if, for example, they marked that they had sex while under the influence in 2022 but did not have sex while under the influence in 2023 or 2024. As a result, these service users are double counted in the numerators of both groups but not in the denominator, meaning that the proportions of both groups would be greater than 100.

Furthermore, this double counting may skew comparisons between the two groups (service users who engage in sex while under the influence vs. service users who do not engage in sex while under the influence). This is because individuals may be counted in both groups, making the groups appear more similar than they actually are. This is called 'contamination'.

At the same time, individuals who have multiple values for certain demographic characteristics, may be counted in the breakdown of characteristics unequally between groups. For example, say an individual engages in sex while under the influence in 2022 and is in the 35-44 age group in 2022. Then in 2023 they no longer engage in sex while under the influence and are now in the 45-54 age group. This would cause the age profile of individuals who engage in sex while under the influence to appear younger than the profile of individuals who engage in sex while not under the influence, even though they include some of the same individuals. This is called differential misclassification because the groups would be impacted differently.

To determine how best to sample service users from SHL data to remove these sources of bias, Public Health conducted two analyses using three designed samples. The three samples included in these analyses are detailed in Table 11.

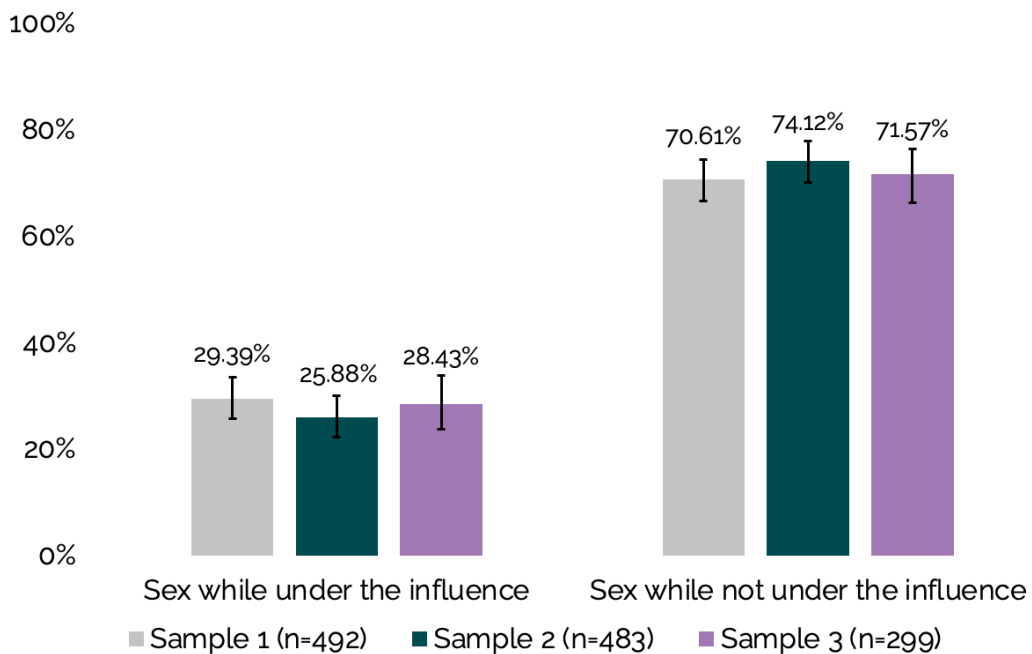
Table 11. Details of the samples from SHL data constructed by Public Health for sensitivity analysis.

Sample 1	Sample 2	Sample 3
City of London: n=492	City of London: n=483	City of London: n=299
Hackney: n=7755	Hackney: n=7749	Hackney: n=4669
This sample includes all unique service users in the original dataset, without modification. As a result, users are double counted in numerators and the sample is subject to contamination and differential misclassification.	This sample includes the most recent entry for each unique service user. This means that each unique service user is accounted for only once in each numerator for each characteristic; however, the numerator in which they are counted is the value of the characteristic for that most recent entry. For example, if an individual marked that they engaged in sex while under the influence in 2022 and 2023, but not in 2024, they would be counted in the numerator of	This sample does not include anyone who ordered SHL testing kits in multiple years between 2022-2024; therefore, each unique service user only has one unique value for each characteristic and cannot be double counted across multiple numerators.

	individuals who did not mark having sex while under the influence. This sample is subject to potential differential misclassification.	
--	--	--

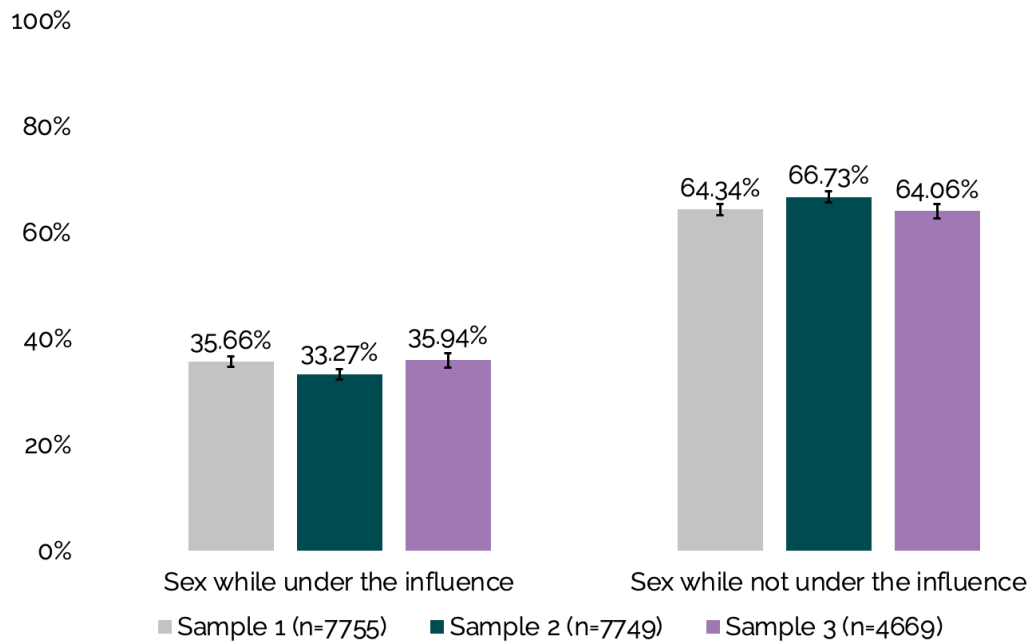
Public Health first compared the proportion of service users who marked that they engaged in sex while under the influence of drugs across all three samples in both City and Hackney. While each sample returned slightly different proportions, these differences were not statistically significant, meaning that estimates of the proportion of service users engaging in sex while under the influence were not significantly skewed in any sample (Figures 29 & 30).

Figure 29. SHL service users from the City of London by reported engagement in sex under while under the influence, 2022-2024.



Source: Preventx. SHL service users from the City of London, 2022-2024. 2025.

Figure 30. SHL service users from Hackney by reported engagement in sex under while under the influence, 2022-2024.

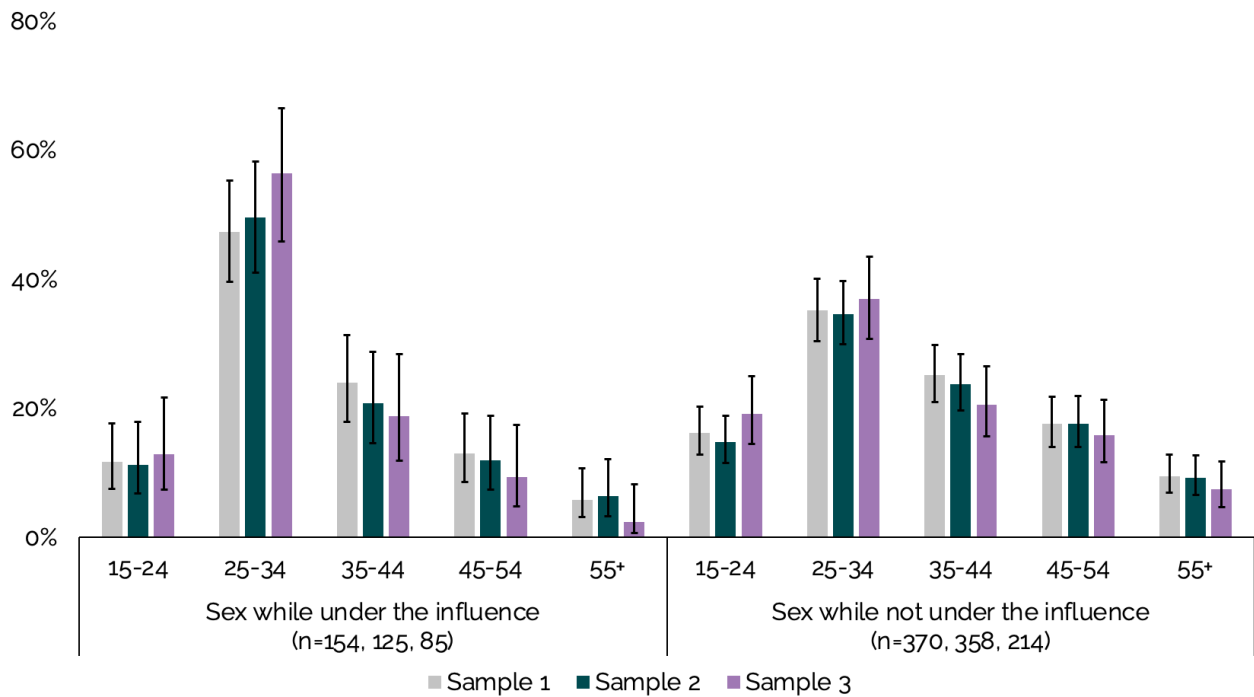


Source: Preventx. SHL service users from Hackney, 2022-2024. 2025.

Public Health then conducted an additional analysis to compare the age breakdown of each group in each sample in both City and Hackney. Age was chosen as the test variable because it had the highest potential for misclassification between the groups of any demographic characteristic. This is because of all demographic variables, age had the greatest number of unique users who could be double counted between groups (Table X).

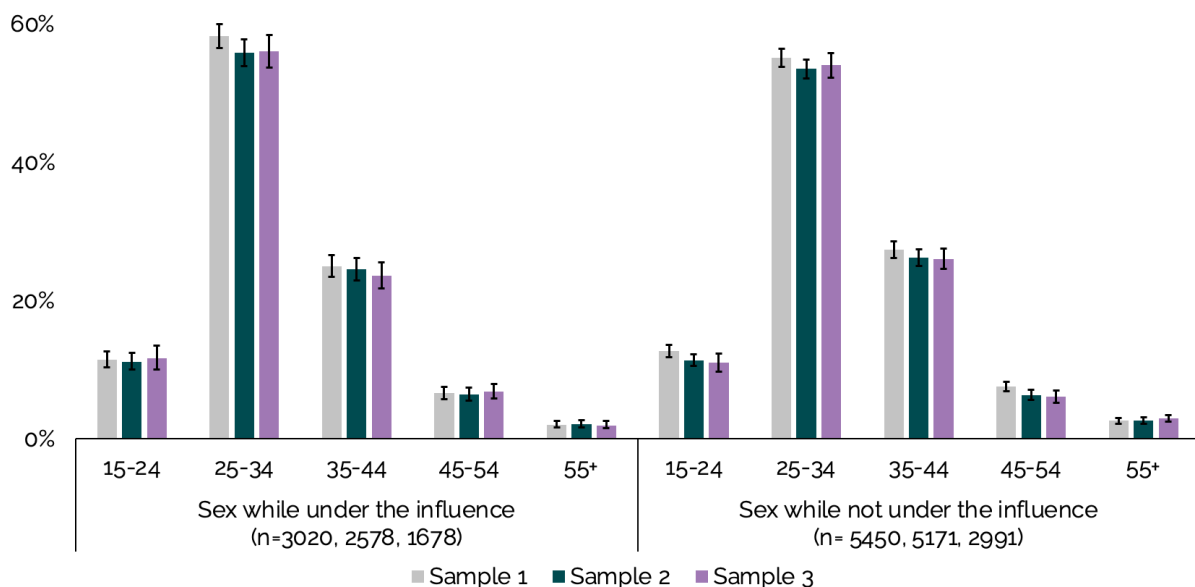
Similarly, each sample returned slightly different breakdowns by age; however, no estimated proportion of any age group was statistically significantly different across any of the three samples for any group in either City or Hackney (Figures 31 & 32). This means that the age breakdown of both groups was not significantly skewed in any sample and the comparison of age breakdown between groups could be considered valid for samples 2 and 3, since neither of these samples doubled counted service users.

Figure 31. SHL service users from the City of London by age and reported engagement in sex while under the influence, 2022-2024.



Source: Preventx. SHL service users from the City of London, 2022-2024. 2025.

Figure 32. SHL service users from Hackney by age and reported engagement in sex while under the influence, 2022-2024.



Source: Preventx. SHL service users from Hackney, 2022-2024. 2025.

Given that neither sample 2 nor sample 3 significantly skewed estimates of prevalence or comparisons of demographic characteristics between groups, Public Health chose to use sample 2 for all descriptive analyses of SHL demographic data. This is because it contains the most number of unique service users without double counting service users in any numerator, allowing for the more precise calculations of descriptive statistics.

Appendix 3: Aggregation of ethnicity data from SHL

Table 11. Ethnic group categories developed by Public Health based on reported ethnicity in SHL data.

Reported ethnicity	Ethnic group category
Bangladeshi	Asian
Chinese	
Indian	
Pakistani	
Other Asian Background	
African	Black
Caribbean	
Other Black Background	
Latin American	Latin
White and Asian	Mixed
White and Black African	
White and Black Caribbean	
Other Mixed Background	
Any other group	Other
I'd rather not say	Not stated
White British	White
White Irish	
Other White Background	