Written evidence from London Friend

Introduction

1. London Friend is a charity working to improve the health and wellbeing of lesbian, gay, bisexual and trans (LGBT) people. We were founded in 1972. Our focus is largely on mental health; sexual health; domestic abuse; and substance misuse. Our work consists of direct delivery of support to LGBT people; engagement of LGBT people to support others from their communities through structured volunteering; training and consultancy on LGBT health and wellbeing, good practice, and related issues; and strategic work to improve policy and practice around health and social care for LGBT people, based on the lived experience of our service users.

www.londonfriend.org.uk

2. Our drug and alcohol service Antidote provides psycho-social support to LGBT people seeking to stop problematic drug or alcohol use, and provide harm reduction information to those seeking to reduce their use and reduce the risks of associated harms.

3. We have managed the Antidote service since 2011, when it moved from Turning Point in Westminster. Our CEO Monty Moncrieff MBE established the Antidote service in 2002 whilst employed by Turning Point, and joined London Friend shortly after the Antidote service transferred. The Antidote Service Manager, Toni Hogg, has volunteered and worked with the Antidote service since 2003, and was previously a volunteer with its predecessor, Project LSD. Together they have the most extensive experience of supporting LGBT drug and alcohol clients in the UK. In 2018 Moncrieff published a paper *Towards a supportive policy and commissioning environment for chemsex in England* examining the development of responses to chemsex.

4. The Antidote service was the first to identify the emerging patterns of sexualised drug use in gay and bisexual men now known as chemsex. Antidote has the most extensive experience of working with chemsex of any UK agency, since 2008, and has developed specific treatment and support packages for gay and bisexual men. London Friend has trained many hundreds of health and social care practitioners and services on chemsex.

5. In 2014 we published Out Of Your Mind, a report aimed at improving drug and alcohol treatment for LGBT clients. This includes guidance for commissioners, service providers, and individual practitioners as well as recommendations for Public Health England, many of which were enacted. The report also includes focus groups where LGBT people shared their experiences of drug and alcohol treatment services.

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1. [https://doi.org/10.1071/SH17188](https://doi.org/10.1071/SH17188)
2. [http://londonfriend.org.uk/outofyourmind](http://londonfriend.org.uk/outofyourmind)
6. This response focusses on those issues affecting LGBT people in relation to Drug Policy, which are often overlooked in strategies and practice.

Health and harms:

What is the extent of health harms resulting from drug use?

7. LGBT people are significantly more likely to use drugs\(^3\). Higher levels of use are consistently reported in research into LGBT communities. The Crime Survey for England and Wales periodically provides data disaggregated by sexual orientation. The most recent release, from 2014\(^5\) shows that gay and bisexual men were three times more likely to have used an illicit drug in the previous year (33%) than heterosexual men (11.1%). Lesbian and bisexual women were over 4 times more likely to have taken an illicit drug (22.9%) than heterosexual women (5.1%). Research on use by gay and bisexual men is more readily available than for lesbian and bisexual women; for bisexual people generally; and for trans people.

8. A large amount of the drug use by LGBT people has traditionally been ‘club’ drugs or ‘recreational’ use. Drugs such as ecstasy have trended to be viewed as less harmful than drugs such as heroin or crack cocaine. However, with the emergence of chemsex we have seen a level of harm not previously widely experienced in the LGBT community. The emergence of drugs that are most closely associated with chemsex – crystal methamphetamine, GHB/GBL, and mephedrone – has been accompanied by much greater harms to mental health; injecting harms (the practice of injecting in a chemsex context is known as ‘slamming’); and risk of dependence.

9. The harms associated with GHB/GBL have historically been poorly understood. We began to see dependence on GHB/GBL in the late 2000s, but were initially unaware of the risks of unsupervised withdrawal. Many gay and bisexual men became dependent without knowing there was a risk of this happening. A reduction in the number of dependent presentations suggests that harm reduction information warning of the risk of dependence has been effective. However, as GHB/GBL carries a significant risk of overdose due to the very small amounts of the drug needed to produce a euphoric effect, this continues to present a very significant risk to users. A study by Imperial College identified a very sharp increase in GHB/GBL related deaths, and the drug was implicated in the conviction of Stephen Port for murder and sexual assault. Additionally we are aware of a growing number of gay and bisexual men who experience sexual assault as a result of acute overdose on GHB/GBL. Anecdotal evidence and intelligence held by the Metropolitan Police suggests this can sometimes be deliberate overdosing by a predatory individual or group of individuals, rather than accidental.

\(^3\) [https://www.ukdpc.org.uk/publication/the-impact-drugs-different-minority-groups-lgbt-groups/](https://www.ukdpc.org.uk/publication/the-impact-drugs-different-minority-groups-lgbt-groups/)


10. In 2018 St George’s Hospital in South London published data outlining the much greater risks of harms associated with crystal methamphetamine. Their study examined reported incidence of harm by men engaged in chemsex, comparing reports where crystal methamphetamine was used, with chemsex not involving crystal. The measures included impact on mental health; relationships; time off work; hospital admissions; financial; overdose; and involvement with the criminal justice system. Overall 84% of people reported a negative consequence where crystal was included in chemsex, compared to 47% where it was not. Reporting was much higher across all measures where crystal was used.

**Prevention and early intervention:**

*What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.*

11. Anecdotal evidence from services users indicates that the main primary reason for drug use is fun. Like alcohol, drugs can offer a highly enjoyable experience and help lower inhibitions. Clients tell us about the empathy they can feel for fellow users and can experience intense bonds with others. This is common for all use in social contexts. With chemsex the primary reason for using is to enhance and prolong sex. Service users also tell us this lowers inhibitions and can alleviate anxiety about sex and intimacy. Understanding the motivating pleasure factors and the role that drug use can play in LGBT and chemsex communities is vital in developing interventions and harm reduction strategies, and it is important to drug users who use in these contexts that they have confidence such interventions have integrity.

12. It is important to note that not all use will be initiated due to pleasure; services users also tell us that use may stem from boredom, isolation, and a feeling of wishing to belong to a community (e.g. the gay ‘scene’, or chemsex parties where use occurs). This is also now emerging in research. Additionally LGBT people may use drugs in a so-called ‘self-medicating’ context as a ‘coping strategy’ in attempts to deal with the elevated levels of prejudice, harassment, and discrimination LGBT people can experience.

13. Regarding the sustained use of drugs in LGBT communities the picture is diverse. Some use will be sustained on a social or recreational level, in sexual and non-sexual contexts, because it remains fun and pleasurable. In chemsex drugs intensify the sexual experience and users wish to continue to experiences these pleasures. Using can quickly become the norm and be the main focus of social engagement, particularly at weekends. Given the sense of community people can feel in these settings notions of giving up drug use can be very closely intertwined with fears of losing this sense of belonging. This can add to the fear of stopping or reducing, and may lead to people continuing to use drugs even where they are experiencing other negative consequences of using, such as mental and physical health issues; financial difficulties; relationship problems or missing work.

**Treatment and harm reduction:**


How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate. Is policy sufficiently geared towards treatment? This includes the extent to which health is prioritised, in the context of the Government’s criminal justice-led approach.

14. Despite higher levels of use, there is evidence to suggest that LGBT people who are not using opiates, and gay and bisexual men who are engaged in chemsex, are not seeking treatment in large numbers from mainstream drug treatment agencies. Many gay and bisexual men initially seek chemsex support from sexual health clinics. The Chemsex Study\(^8\) indicated that gay and bisexual men preferred to get support in these settings, which many are more familiar and comfortable with, or from community services such as our own.

15. Antidote’s early experience of working with chemsex was that most ‘mainstream’ drug treatment services had little experience of it, and had poor knowledge of the drugs used; the sexual context of use; and particularly the wider social factors impacting LGBT people. Requests for interventions such as detoxification for GHB/GBL were often met with confusion and few local treatment pathways were in place. Although drugs knowledge has generally improved greatly over time, many service users still tell us they do not feel the contexts of their using and experiences as LGBT people are fully understood by mainstream services, and do not feel these services will meet their needs.

16. Focus groups conducted for the Out Of Your Mind report indicated many LGBT people did not feel safe or understood in mainstream treatment services. Many highlighted barriers to accessing treatment, such as poor knowledge of the drugs they were using, or of their lifestyles as LGBT people and the context of their use. Sometimes previous experience of discrimination or hostility in other healthcare services put them off accessing support. Many spoke of the need to be open about potentially sensitive or embarrassing issues, such as sexual behaviour they later regretted, and felt unable to do this in mainstream services.

17. London Friend and our Antidote service has provided training to a very large number of drug treatment and sexual health services on chemsex, and provided guidance for good practice in the Out Of Your Mind report. It is our view that practitioners and services possess the skills required to support LGBT people seeking drug treatment, although a) LGBT people themselves may not perceive this to be the case; and b) many services lack the cultural competence to support LGBT people effectively. Problematic drug use by LGBT people, particularly chemsex, is associated with extremely complex feelings around LGBT identities and belonging, which can be very closely linked to experiences growing up LGBT. This is only beginning to be fully understood, and our service users tell us they seek specialist LGBT support as they feel this is essential for them.

**Best practice:**

\(^8\) [http://sigmaresearch.org.uk/projects/item/project59](http://sigmaresearch.org.uk/projects/item/project59)
What would a high-quality, evidence-based response to drugs look like? What responses to drugs internationally stand out as particularly innovative and/or relevant, and what evidence is there of impact in these cases?

18. The Drugs Strategy, policy and commissioning practice can inadvertently exclude LGBT people. There has historically been a focus on heroin and crack in both strategy and treatment, including a significant historic financial investment from criminal justice focusing on these two drugs. Treatment services have followed these policies and established services whose primary focus is heroin and crack users. The UK Drug Policy Commission’s 2010 report on LGBT communities found that LGBT people often felt these services were not relevant to them; this was echoed strongly in the focus groups we ran for the Out Of Your Mind report.

19. The 2010 Drugs Strategy included a single reference to LGBT people, indicating that treatment services needed to “be responsive to the needs of specific groups such as …. Lesbian, Gay, Bisexual and Transgender users”. This provided leverage to services seeking to improve work with LGBT communities that this was part of the Government’s strategy. The 2017 Drugs Strategy removed this reference. It did include explicit references to chemsex for the first time, but this omission means there is less explicit responsibility for, or consideration of, LGBT people in the Government’s strategy.

20. The commissioning responsibilities for drug treatment services can also be a barrier to effective work with LGBT communities. This is particularly an issue in London where we are based, with 33 local authorities commissioning treatment services for local residents. Experience within these services can be a ‘postcode lottery’ for local residents. Unlike sexual health services, where patients have a choice of clinic to use, access to drug treatment is on basis of residency. This means that even where a service has worked to ensure LGBT inclusion and competence, a service user may not be permitted to use it as they are not a local resident.

21. Such local arrangements can also restrict what is being commissioned. In the current financial climate of significant cuts to public health budgets commissioners do not usually have the ability to commission specialist work. Capacity often means one local service will be commissioned. This means that organisations like ours that are doing specialist work can only enter the local marketplace via a sub-contracted arrangement with a larger provider. Such arrangements are difficult to facilitate, and although we are sub-contracted providers in two sexual health contracts, to date there has been no sub-contracted provision of drug treatment in London to a specialist LGBT service.

22. We explored the advantages and disadvantages of several models for specialist LGBT provision of drug treatment in the Out Of Your Mind report. In this only 12% of our service users told us they would have felt comfortable discussing their treatment needs in a mainstream service. This suggests that with the continuing reluctance of commissioners to provide specialist LGBT services, or to explicitly request these of their providers, and the
seeming reluctance of providers to sub-contract with specialist providers, a great many LGBT people are simply not having their treatment and support needs met under the current arrangements.