A Thematic Safeguarding Adult Review

in the context of 'chemsex'-related harms

Hammersmith and Fulham

Safeguarding Adults Board

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"When gay men approach services, they are often looking out for cues from professionals that show it is ok to say that they are gay, never mind talking about drugs or sex, or drugs *and* sex. So, it would be much more difficult to talk about specific sexual practices that professional might be unfamiliar with or even embarrassed by"

"Chemsex is about making connections, having great sex, everyone looks great, and when you are in control, you are having a great time. But it can degenerate to very concerning issues and life collapses around them"

"People say 'I agreed to go there', but that doesn't mean that they knew what was going to happen with specific sexual partners over the course of hours or days, when intoxicated or incapacitated. Does that consent still apply?"

"Chemsex is hugely complex. It is challenging to talk about the 'good' side of drug use whilst keeping a focus on the possible impact and harms of using these drugs, but we also need to be cautious of moral panics"[1]

[1] These quotes were shared by practitioners contributing to this SAR. They illustrate the nuanced and complex landscape of supporting individuals who experience chemsex related harms.

Glossary and Acronyms

Chemsex – the "intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men", involving specific drugs (GHB/GBL, crystal methamphetamine and mephedrone) in combination, to facilitate prolonged sexual sessions[2]. These drugs are sometimes referred to together as "chems".

Crystal Meth – A 'Class A' methamphetamine stimulant drug which is usually smoked causing a very intense and long lasting high. This can make you feel exhilarated, alert and aroused – inhibitions are lowered and sex drive can be increased – but it can also cause agitation, paranoia and aggression. It is closely associated with chemsex[3].

GBMSM – Gay, Bisexual, Trans and other men who have sex with men. This term reflects groups commonly served by chemsex services. Not all GBMSM take part in chemsex.

GHB / GBL - Closely related sedative drugs. When consumed, GBL is converted into GHB in the body. It is often taken orally in soft drinks. It is very easy to overdose on GHB and GBL - there is only a small difference between the dose causing the desired effects and the dose leading to severe overdose. People who use this measure it out carefully or by using pre-measured small bottles (vials). It is common to 'go under' (black out / lose consciousness) when taking this drug. Its effects include euphoria, relaxation and feeling 'turned on'. They are closely associated with chemsex[4].

Hook-Up Apps – Smart phone apps are used by GBMSM to meet for sex. These usually use geo-location to identify other men in the same area and brings an immediacy to such hook-up encounters.

LGBTQ+ - Lesbian, Gay, Bisexual, Trans, Queer and Other Sexual and Gender Diverse identities.

Mephedrone / MCAT – A Class B stimulant drug, which is snorted, swallowed or injected. It can cause alertness, confidence but also anxiety or paranoia. It is closely associated with chemsex[5]. Police and gay men's health services participating in the SAR indicate that it has been less available recently. It does not feature in the chronologies of the men in this review.

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[2] McCall, H., Adams, N., Mason, D. and Willis, J. (2015) What is chemsex and why does it matter? BMJ; 351:h5790 doi:10.1136/bmj.h5790.

[3] https://talktofrank.com/drug/methamphetamine

[4] https://talktofrank.com/drug/ghb

[5] https://talktofrank.com/drug/mephedrone

1. Background

1.1 In January 2025, the Hammersmith and Fulham Safeguarding Adults Case Review Group received a referral following the death of a man with care and support needs and who participated in chemsex. This multi-agency group make decisions about the thresholds for commissioning safeguarding adults reviews[6] (SARs). A SAR is a statutory report which is commissioned on a mandatory basis when an adult with care and support needs has died or experienced significant harm in the context of abuse or neglect and it is considered that multi-agency partners could have worked more effectively to support the adult. Outside of this, SARs can be commissioned on a discretionary basis when it is not clear that this threshold has been met. SARs can also be commissioned to respond thematically to patterned circumstances or experiences. As chemsex is an emerging phenomenon noticed by public health, the NHS, drug treatment and criminal justice partners, the SAB recognised the benefits of a thematic review that would include several other adults who had died in the context of chemsex. Some of these men were included on a discretionary basis given the potential for thematic learning, even if the statutory mandatory threshold was not met.

1.2 To preserve the confidentiality of the men concerned, detailed chronologies and characteristics of the men are not shared in this report. Additionally, the men involved have not been ascribed pseudonyms in this report as is usual practice in SARs. Instead, composite cross-case findings are used to maintain confidentiality while allowing for a focus on learning. While this may risk de-personalising the report, a decision was taken to take this approach to allow the learning to be published without compromising the anonymity of the men. The SAB have been appraised of more micro-level data about the individual men to support the recommendations where needed.

1.3 Karl Mason was appointed as an independent consultant to lead the SAR process. He has practice, leadership and research experience in the safeguarding sector and identifies as a gay man.

2. The Chemsex Context

2.1 Chemsex has been defined as “intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men”, involving specific drugs (GHB/GBL,

[6] The purpose and underpinning principles for SARs are set out in section 2.9 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

crystal methamphetamine and mephedrone) in combination[7]. Prevalence among gay, bisexual, trans and other men who have sex with men (GBMSM) is difficult to pin down and estimations vary greatly across studies[8]. Men who participate in chemsex do so for a variety of reasons. Some studies emphasise the role of self-esteem and social isolation from a psychological perspective, but others emphasise the role of culture, noting that chemsex prevalence increased in parallel to the closure of many LGBTQ+ nightlife spaces for socialising and partying in London[9]. However, chemsex is mainly motivated by the enhancement of sexual experience, escape, adventure and pleasure. Sexual pleasure is a universal need and efforts to enhance this are not confined to GBMSM. Other research[10] argues that chemsex is just one type of broader sexualised drug use, embarked upon by people of all sexualities and genders. It is also not correct to suggest that a majority of GBMSM engage in chemsex. Charities in the sector argue that this wrongly suggests that chemsex is an essential characteristic for GBMSM and therefore inevitable. Chemsex is often facilitated through apps that use geolocation features to allow immediacy of contact. Chemsex may occur between sexual partners, when alone or in preparation to meet a partner. Chemsex parties bring multiple partners together, sometimes in prolonged sessions. These may occur in private homes, hotels, sex-on-premises venues, public parks[11] or online[12].

2.2 This is relatively new terrain for safeguarding adults, though one SAR has previously been published by another SAB in England (see section 4.7). Safeguarding is a multi-agency endeavour, and it is important to note that the literature on chemsex reflects a lack of a shared language to contextualise chemsex. Public health perspectives initially emerged to reflect the significant health concerns and risks of overdose or long-term mental health impacts. An alternative perspective reflects contextual factors around the

[7] See McCall et al – Footnote 2.
[8] Edmundson, C., Heinsbroek, E., Glass, R., Hope, V., Mohammed, H., White, M. and Desai, M. (2018) Sexualised drug use in the United Kingdom (UK): A review of the literature, International Journal of Drug Policy, 55: 131-148.
[9] Hakim, J. (2019). The rise of chemsex: Queering collective intimacy in neoliberal London. Cultural Studies, 3(2), 249–275.
[10] Moyle, L., Dymock, A., Aldridge, A. and Mechen, B. (2020) Pharmacosex: Reimagining sex, drugs and enhancement, International Journal of Drug Policy, 95: 103282, https://doi.org/10.1016/j.drugpo.2021.103282
[11] Hawkinson, D., Witzel, T.C. and Gafos, M. (2024) Exploring practices to enhance benefits and reduce risks of chemsex among gay, bisexual, and other men who have sex with men: A meta-ethnography, International Journal of Drug Policy, 127, 104398, https://doi.org/10.1016/j.drugpo.2024.104398.
[12] Møller, K. (2020). Hanging, blowing, slamming and playing: Erotic control and overflow in a digital chemsex scene. Sexualities. https://doi.org/10.1177/1363460720964100

closure of LGBTQ+ nightlife spaces[13]. Some perspectives argue that chemsex has been subjected to medicalisation and professionalisation, but that professionals are not prepared for this work, nor are they best placed to lead on it and that peer support is more appropriate[14]. Meanwhile, policing roles around chemsex have emerged due to overlay with sexual assault, sexual exploitation, acquisitive crime, and several high profile homicides[15],[16]. These differing perspectives are all likely to emerge in safeguarding work when health, social care, policing, housing and community services come together, though these perspectives may not be as siloed in actual practice. Importantly, safeguarding adults is about offering support to adults with care and support needs who experience abuse and neglect and cannot protect themselves due to their needs[17]. Ethics of person-centred empowerment and community strengths are balanced against risk, abuse and exploitation[18]. Safeguarding may apply in some chemsex circumstances where these conditions are met, but there is a need for role clarity to promote effective support and avoid moral panics or alienating those experiencing harm[19].

2.3 Safeguarding practitioners should, however, be aware that chemsex can have specific associated harms. Crystal meth use can cause significant mental ill-health such as paranoia and psychosis, which may worsen existing issues for those with care and support needs or cause new concerns. GHB/GBL can cause loss of consciousness ("going under") and even death and the difference between the measures that create the desired effects and death are small. It is unhelpful to conflate chemsex with more general poly-drug use as the broader scene and sexualised context in which it occurs.

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[13] See Hakim (2019) as per footnote 12. Similar arguments are made in Mowlabocus, S. (2021) Fucking with homonormativity: The ambiguous politics of chemsex. *Sexualities*, *26*(5-6), 585-603. https://doi.org/10.1177/1363460721999267.

[14] Nagington, M., & King, S. (2022). Support, care and peer support for gay and bi men engaging in chemsex. Health & Social Care in the Community, 30, e6396–e6403. https://doi.org/10.1111/hsc.14081

[15] Davis, A., Morris, S., Shell, Y. and Unwin, R. (2022) Crime and Vulnerability in the Chemsex Context: A criminal justice working definition, London: Metropolitan Police.

[16] Metropolitan Police and HM Prison and Probation Service (undated) Project Sagamore: A Partnership Response to the Evolution of Chemsex Crime; Harms & Vulnerabilities, London: Metropolitan Police.

[17] See Care and Support Statutory Guidance.

[18] Lawson, J. (2021) The 'Making Safeguarding Personal' Approach to Safeguarding, In Cooper, A. and White, E. (Eds.) Safeguarding Adults Under the Care Act 2014: Understanding Good Practice, London: Jessica Kingsley.

[19] Heritage, F., and Baker, P. (2022). Crime or culture? Representations of chemsex in the British press and magazines aimed at GBTQ+ men. Critical Discourse Studies, 19(4), 435–453. https://doi.org/10.1080/17405904.2021.1910052.

2.4 A variety of harm reduction approaches are identified in the literature, including personal preparation by storing belongings safely, setting personal boundaries, watching out for others, and teaching and learning from others[20]. However, adults with care and support needs may, in some cases, struggle to adopt such approaches. This may be more apparent when overlaid by other issues such as multiple exclusion, mental ill-health, trauma or broader substance use issues. Harm reduction approaches require trust in partners and agency to manage boundaries (Hawkinson et al, 2024) which may also be difficult for example when dependent on these drugs.

2.5 Several high profile cases have appeared in the media, most notably the murder of four young men, Anthony Walgate, Gabriel Kovari, Daniel Whitworth and Jack Taylor, by Stephen Port in East London[21]. Port met these men online on separate occasions and killed them by issuing a lethal dose of GBL. These murders are clearly horrific, but the case is also important because it has illustrated a range of policing failings in the investigation[22]. The Metropolitan Police service, in conjunction with HM Prison and Probation Service set up Project Sagamore to address crime related risk, harm and vulnerability within the chemsex context. An important function of this project is to address the governance issues in relation to such deaths. Very sadly, these issues have been repeated in the death of Edward Cornes reported on in the Times[23] during this review period. He was a 19 year old student and within 48 hours of arriving to university for a new term, he was found dead in a nearby B&B where he had met two men in their 50s. Again, the police have faced significant criticisms around their handling of the investigation.

2.6 While attitudinal issues within the police force have been highlighted, specifically homophobia[24], the safeguarding sector needs to consider how prepared the broader workforce is to support GBMSM in relation to sexualised drug use. As services encounter the phenomenon of chemsex more regularly, this is a crucial consideration.

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[20] See Hawkinson et al (2024) as cited above.
[21] www.theguardian.com/uk-news/2021/dec/10/stephen-port-case-the-missed-opportunities-to-catch-a-serial-killer
[22] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/inspection-of-the-metropolitan-police-services-response-to-lessons-from-the-stephen-port-murders.pdf
[23] https://www.thetimes.com/uk/crime/article/met-were-more-interested-in-smearing-our-gay-son-than-his-cause-of-death-qg9lhp0s6
[24] www.theguardian.com/uk-news/2023/mar/21/metropolitan-police-institutionally-racist-misogynistic-homophobic-louise-casey-report

2.7 One previous SAR has been commissioned to address circumstances where chemsex appears to be indicated.

2.7.1 **Jonah (2022) Bexley SAB** – Jonah was a 35 year old man recently separated from his girlfriend. He is said to have experienced conflict regarding his sexuality and began using cocaine and crystal meth in this context. Jonah had five hospitalisations due to crystal meth use including three that were documented as following sexual encounters with men. The SAR indicates that sexual assaults or exploitation should have been considered due to the descriptions he gave. There was no evidence that sexual health was discussed with him.

2.8 A small number of Domestic Homicide Reviews include reference to chemsex. The circumstance of these are somewhat different but they do offer some potential learning.

2.8.1 **AJ (2023) Manchester** – AJ was a gay man with emotionally unstable personality disorder who died at home following an overdose of medication. He had disclosed to services that he participated in chemsex parties with his partner, who he said could be controlling. AJ disclosed that he was sometimes given drugs as payment to have sex with other men. Agencies did not recognise that AJ may have been exploited in this situation and were unaware of a local service offering chemsex support. Recommendations were to update safeguarding policies to include chemsex pathways and to promote the local chemsex support service.

2.8.2 **Sajwa (2022) Tower Hamlets** – Sajwa was a woman of Pakistani heritage who was murdered by her brother Amir. Amir identified as a gay man and used crystal meth and GHB/GBL, which appeared to be in a chemsex context. Substantial mental health concerns were evident including police and hospital contact due to aggressive or erratic behaviour. The review observes some organisations needed greater intersectionality awareness around religion, culture and sexuality when working with those using 'chems'.

2.8.3 **Anthony (2022) Milton Keynes** – Anthony and Terry had had an apparently 'casual' sexual relationship for several weeks. Terry later told police that during sex, Anthony shared his positive HIV status. This allegedly infuriated Terry who murdered Anthony and set the flat on fire. Terry told the police in a statement that Anthony had taken GHB and they were both using drugs during sex – the term chemsex is used. A recommendation was made that GP practices could do more to screen for drug and alcohol issues.

2.9 Local data and service mapping - Colleagues from public health in Hammersmith and Fulham shared there has been an increase in the use of 'chems' locally, particularly noted through disclosures via sexual health services. The police shared that the tri-borough area covering Westminster, Kensington and Chelsea, and Hammersmith and Fulham) is known to their service as having some of the higher rates of chemsex in London. London Friend, a LGBTQ+ health and wellbeing organisation operating across the city, indicated that Hammersmith and Fulham is their joint eighth busiest service. Initiatives underway in Hammersmith and Fulham include an audit of Emergency Department presentations and a set of focus groups around lived experience. In the borough, there are sexual health services attached to the hospital sites as well as a club drug clinic and a social enterprise called SASH (Support and Advice on Sexual Health) who have some funded co-located positions in local sexual health services. London Friend also have a funded role co-located with the drug and alcohol service. Certainly, there are a number of initiatives in the borough which indicate strategic buy-in and innovation and it was good to hear stakeholders with oversight of chemsex services in other boroughs stating that Hammersmith and Fulham was a case study for good practice in their commissioning.

3. Methodology

3.1 An initial meeting on 19/07/2025, between the lead reviewer, the SAB manager and the public health lead, agreed the draft terms of reference and draft key lines of enquiry (KLOEs). Governance for the SAR process was undertaken through a panel[25] who met twice (20/10/2025 and 29/01/2026). They approved the KLOEs, the practitioner event proposal and the final report. The lead reviewer visited the homelessness accommodation where one of the men had lived and met staff members there. Chronologies were requested from all services represented by the panel. A practitioner event was held on 01/12/2025 and was attended by 12 practitioners from SAB agencies who provided insights into the issues encountered in work with the men at the heart of this review.

[25] The panel was composed of members from public health, drug and alcohol services, Metropolitan Police, the integrated care board, the mental health trust, two acute hospital sites, adult social care, children's social care, the homeless health service, a homelessness accommodation provider and a specialist police service who deal with high harms associated with chemsex, Project Sagamore.

3.2 Family involvement[26] – Given the sensitive issues encountered within this SAR, including known and recorded requests for no information sharing with family members, the SAR panel took the decision to conduct the SAR without family involvement.

3.3 Parallel processes: The coroner's office was informed of the SAR by the SAB business manager. No report was yet available by the coroner for any of the men. The police are no longer investigating any of the deaths. No other parallel processes were disclosed.

4. Key Lines of Enquiry

4.1 Several overarching and thematic Key Lines of Enquiry (KLOEs) were established.

- KLOE 1: Was there evidence that chemsex and its unique characteristics were understood by SAB partners and that effective responses were in place to explore and address the attendant risks and drivers for individual engagement with chemsex related activities?
- KLOE 2: To what extent were individual's protected characteristics and intersectionality factors, such as care leaver status, substance use (including chemsex), mental health needs, and social isolation recognised and understood by professionals, and how effectively did this inform the prevention of harm and the provision of support? What lessons can be learned to improve identification, early intervention, and multi-agency responses for individuals with similar vulnerabilities?
- KLOE 3: Was there evidence that the individuals experienced exploitation or abuse, including physical and sexual assault, criminal or sexual exploitation? Where such concerns were identified, were police and other statutory agencies effectively engaged in multi-agency safeguarding processes, including protection planning to reduce drug related harm and/or disrupt exploitation networks, and able to address risks associated with substance misuse? How were any disclosures of exploitation or abuse addressed, both in terms of the criminal justice response and the provision of trauma-informed support?
- KLOE 4: What role did digital platforms, play in the individual's experience of harm, exploitation, or risk? To what extent did agencies recognise and respond to the potential safeguarding implications of online contact and digital environments, including in relation to chemsex, exploitation, or social isolation?

[26] As per SAR Quality Marker 11

- KLOE 5: Did health partners, including Emergency Departments, mental health, sexual health and substance misuse services, provide support to the individuals? If so, were presenting risks recognised and responded to in line with local safeguarding policies, clinical pathways and strategic priorities for community safety and harm reduction?

5. Thematic Review Findings and Analysis

5.1 – KLOE 1: Learning related to Chemsex

Learning in summary:

Practitioners need to be 'chemsex-aware' in order to know what questions to ask and what advice to offer. It is not helpful to conflate general substance use and chemsex due to the specific associated harms and context in which it occurs. The language of risky relationships also lacks specificity to guide support in this area. Those working with people with care and support needs who engage in chemsex should be aware that people usually take part in chemsex because it enhances sexual pleasure or allows intimacy and connection. Addressing these unmet needs is a more helpful starting point than solely focusing on risk and harm. However, there are also specific harms that chemsex is associated with, including risks of overdose, loss of consciousness and death and risks related to consent, sexual assault and sexual exploitation. Practitioner knowledge around these aspects of chemsex is crucial in offering support to those adults with care and support needs (and others depending on agency remits) who identify concerns. Financial debt to dealers is a concern and professionals should be aware that the clearance of such debt does not remove the risk. Sequences of events that show life spiralling out of control should yield conversations to understand what has gone wrong for the person. Given the stigmas associated with discussing any form of sexualised drug use, people may not proactively disclose this to a professional and therefore, Emergency Departments (EDs) are key sites at which harm reduction and other support should be offered, but there are gaps in identification, awareness, policies and coding issues that invisibilise these presentations in ED settings. However, there are wider workforce training and awareness needs that require addressing.

5.1.1 Across the chronologies, there was evidence of limited awareness and knowledge relating to chemsex by professionals. On many occasions, the men in this review shared information that could have enabled consent-led discussions of chemsex risks and safety

precautions if professionals had been attuned to what chemsex entails. For example, the disclosure of using crystal meth and GHB/GBL (or of sexual partners who used these substances) should, but did not, suggest to professionals that chemsex might be a relevant consideration for enquiry. Although advice about chemsex was sought from the Club Drug service about ketamine use (which can be used in chemsex contexts) in the context of sexual assault, this did not follow many instances of crystal meth or GHB/GBL being mentioned. One of the adults mentioned 'slamming' (injecting drugs) and sexual assaults that occurred in the context of his use of geo-location hook-up apps to professionals and he also went missing for several days, but this did not prompt discussion of chemsex at a multi-disciplinary meeting that discussed his situation. An MDT meeting for one of the men noted that their GHB and Crystal Meth use had increased and discussed 'risky sexual behaviour', but 'chemsex' itself was not named and it would appear this context was also not fully appreciated. It appears these drugs did not imply sexualised drug use to the professionals involved. This specific framing could have helped to guide harm reduction and support. Even when chemsex involvement was disclosed to professionals, there were examples where safer injecting practices were discussed but chemsex support was not. These examples highlight aspects of professional knowledge, curiosity and chemsex awareness that might have prompted earlier and more effective support.

5.1.2 There were other examples, where professional processes that are designed to support the identification of chemsex risks were not followed. There were several examples of sexual health clinic screening that was designed to ascertain chemsex participation not being asked or being left blank. Of concern, toxicology reports for one of the men unexplainedly went missing and could not be sent for further testing when he was admitted to hospital and subsequently died and while a hospital urine screen showed 'amphetamine' use, this has broader connotations. Following his death, the pathologist's initial report stated that he died from drug related consequences and that there was no indication of third party involvement, but notes from the hospital suggest that the scene was described as a 'chemsex party' (the basis for this is unclear).

5.1.3 The men in this review were not known to one another as far as the review has been able to ascertain. They each had different experiences in relation to their chemsex engagement in terms of professional backgrounds, their ages at the time of their death and their engagement with health, social care and other safeguarding services. These aspects

of diverse experience were underpinned in different ways by stigma, shame and secrecy, which may have informed their ability to reach out for professional support around chemsex.

5.1.4 Practitioners from sexual health and the police indicated that many of the people they see in connection with chemsex hold down jobs, sometimes participating in chemsex at the weekend in 'binges' but they compartmentalise this activity, separating their drug use from the rest of their lives. Professionals reported that this can play out through minimising language such as 'chems' rather than 'drugs' or 'going under' rather than 'losing consciousness'. However, many of these men come to the attention of services at points where they begin to struggle. Practitioners working with one of the men in this SAR indicated that he did not see his chemsex engagement as a support need – he reported enjoying these experiences[27]. However, they reflected that he seemed out of his depth, and they referred him to a specialist chemsex service.

5.1.5 A key theme of this SAR is that chemsex harms are different to broader substance use harms. Chemsex involves the use of specific drugs in a sexualised context almost exclusively by GBMSM. The broader poly-drug use of one of the men masked early indicators of chemsex engagement and his use of crystal meth and GHB/GBL may have been assessed as his engaging in what he could access rather than a sign of broader risks and obscuring opportunities for harm reduction. Beyond sexualised drug use, chemsex involves a context and scene that can become all-consuming – for example one of the men had lost his job and home.

5.1.6 Practitioners described a "dark edge" to the scene and the men in this SAR had reported a range of these experiences including violence, acquisitive crime, sexual assault and rape. Chemsex may involve allowing others to inject you and the nature of the drugs may involve loss of consciousness, which creates situations that cannot be consented to and the chronologies included many examples of this including several sexual assaults. Determining what happened can be complex in such situations, for example if multiple partners who are previously unknown to one another are present and the administration of these drugs is unclear. Police contributed that the chemsex scene is networked and power

[27] This reflects a critique of discourses of medicalisation or criminalisation and the understanding that chemsex is principally the pursuit of enhanced sexual pleasure (Hawkinson et al, 2024; Nagington and King, 2022) as discussed in Section 4.1 above.

dynamics exist around age and experience. Allegations of harm caused by two of these men were also suggested but remained too unclear to draw conclusions about in the context of a SAR. For many men, including some of those with professional backgrounds, shame and stigma associated with sexualised drug use may be compounded by realising the overlap with criminality that they would not usually associate themselves with.

5.1.7 During the review, practitioners observed that it might be quite difficult for some professionals to discuss chemsex due to taboos and sensitivities around sex and substance use, including the ways in which individual professionals were socialised around sex that is outside of norms that they are familiar with. Training with a reflexive and sex-positive approach is therefore key. One agency arranged calls with chemsex support organisations to support their work but acknowledged they had never had training that touched on these risks and were not familiar with what chemsex comprised. Sometimes picking up on cues around chemsex could be undermined by the lack of knowledge about drugs more broadly, for instance conflating 'mephedrone' and 'methadone' – two very different substances or calling crystal meth an 'amphetamine' – it is an amphetamine, but this conflates crystal meth with drugs like 'speed', which might obscure whether to offer specific chemsex support as opposed to broader substance use support.

5.1.8 Sex is a personal matter for every individual and some will be more comfortable than others discussing their sex lives. However, chemsex raises other barriers due to an overlay with stigma. Professionals from sexual health services indicated that men disclosing chemsex are often embarrassed, believing that they had let themselves down. Gay men's health and sexual health services said that a significant majority of men attending their services report feeling more comfortable receiving support within LGBTQ+ organisations or from LGBTQ+ professionals in generic organisations. This is important when considering that groupwork is a significant method for offering substance use support, but this might be embarrassing, triggering or unsafe in a non-specialist or heteronormative service. Nonetheless, professionals within generic services should be chemsex-aware, so that they can offer support with chemsex-related harms. Without suggesting unnecessary professional intrusion into people's sexual lives, harmful chemsex does present specific harms, patterns and dynamics that practitioners should be aware of to support those they encounter with harm reduction.

Recommendation 1 relates to training and workforce development needs. Recommendation 2 calls for the development of Emergency Department protocols. Recommendation 3 requests further assurances around police governance. See Section 9 for more details

5.2 – KLOE 2: Learning related to Protected Characteristics

Learning in summary:
Affirmative relationships with professionals are conducive to sharing and exploring risk-taking behaviours. Although some practice was affirmative and no evidence of discrimination was identified, there was limited evidence across SAB agencies of LGBTQ+ identity being accounted for beyond noting it as a characteristic. Domestic abuse supports for LGBTQ+ individuals were not routinely signposted. Although the sector who support people around chemsex needs are increasingly seeing Black, Asian and other people from racialised minority groups who are GBMSM, the ethnicities of the men in this SAR were less diverse and this masks the needs of these groups of GBMSM. A point around dyslexia and non-engagement warrants further consideration if this has not been taken into account in ensuring people with dyslexia have their access needs met before branding their engagement as poor.

5.2.1 Across the chronologies, the men shared characteristics in relation to GBMSM identities. All were open with professionals about their sexualities and relationships when relevant conversation arose. One of the men had quite close working relationships with professionals who were affirmative in relation to his sexual identity and indeed he was allocated to the LGBTQ+ lead in one service. In conversations about sex and sexuality, he would occasionally show his hook-up app profile and the profiles of the men he was meeting to professionals. Sometimes this was sexually explicit, and the professionals wondered if he was attempting to shock them, and they found this difficult to reconcile with their professional role. This might result in diverting him to more serious matters or responding in a casual way, such as “too much information!”. A casual keywork relationship was important to avoid alienating him, but this also created tensions with his levels of risk (See also KLOE 4). It was good to hear that the service sought advice on several occasions from a community-led sexual health advice, even though this man did

not wish to be referred. Two of the men were offered referrals to LGBTQ+ charities, one in the context of stalking and harassment – though it was noted that he was 'unsuitable for MARAC, without any rationale for why this was and there was no evidence of a DASH[28] risk assessment.

5.2.2 Although there are positive examples of engagement with the men's sexual identity by professionals above, there was very little evidence overall in agency records that their sexuality was being considered, beyond initial documentation of their sexual orientation, with some exceptions noted above. None of the men appear to have experienced discrimination within services, but chronologies are not the best way to judge this. Some professionals indicated that they had never encountered individuals reporting homophobic treatment within their service but that other services might have issues. For example, sexual health services indicated that a large proportion of LGBTQ+ clients, specifically GBMSM, have said that they are not 'out' to their GP. From a safeguarding perspective, it is important to recognise that topics such as chemsex or other forms of sexualised drug use may fall outside of some individuals' usual experiences, resulting in varying levels of knowledge, confidence and understanding among staff. This also includes readiness for affirmative practice with LGBTQ+ individuals in general. Affirmative practice is not about simply noting sexuality and not discriminating. It is about creating the conditions and rapport that show you are open to discussing identity-related issues and will not be embarrassed or ill-equipped to attend to these. At the practitioner event, there was an acceptance across most agencies that LGBTQ+ identity is asked about and recorded, but with a level of tokenism and without exploration of what this might mean in terms of lived experience of care and support needs or safeguarding needs. It was described by many agencies at the event as "tick-box diversity". Practitioners reflected that sexual and gender identity are core elements of personhood and acknowledging this is important in understanding what is important to people, around their needs and relationships. In terms of relationships, one of the men had a partner who was only encountered in the chronology after they had died. Another younger adult had older male visitors, and it was not clear who these people were, including a much older man who visited him the day before his death. Although a past relationship with domestic abuse features was acknowledged for one man,

[28] DASH stands for Domestic Abuse, Stalking and Harassment. The DASH risk assessment is widely used across agencies to assess the risks associated with these experiences and may trigger a referral to the MARAC. It may be known under slightly different names in different partnership areas.

the meaning of this relationship and its dissolution was not explored, despite his frequent discussions about loneliness, isolation and poor self-worth. Practitioners reflected on the need to explore these dimensions further in their practice, at the pace of the person they are working with.

5.2.3 The visibility of LGBTQ+ staff is another important consideration. For example, one man's engagement with drug and alcohol services was poor until allocated a LGBTQ+ keyworker. Other services closed his case due to "his" engagement without consideration around whether it was "their" approach that was not working. He clearly felt confident talking about his sexuality and sexual hook ups with staff who were affirmative about his identity. Beyond staff in generic services, London Friend identified that a very large majority of people attending their service say that they feel more comfortable using a LGBTQ+ service. SASH indicated that chemsex and its associated practices may feel like a "very gay" phenomenon that heteronormative services may not feel comfortable talking about – and therefore those needing support will not be left with confidence that it is ok to share such information. SASH also shared examples of people feeling "fobbed off" by their GPs and some examples of homophobic or other ill-judged and non-affirmative, but perhaps unintended, stigmatising responses. Resources such as the Skills for Care LGBTQ+ learning framework[29] may be of assistance to SAB partners to take forward agency learning and skills in this area.

5.2.4 There were also reflections that staff in the safeguarding sector may not have the vocabularies and skills for talking about the different support needs that LGBTQ+ individual may present with. Certainly, there was evidence of an affirmative approach from a number of services, but staff said at times they felt out of their depth in knowing what to do with the information he shared. For example, in relation to one of the men, they indicated that he liked to shock and they were never sure how much of what he said was "bravado" or "bragging" about his sexual and drug-consuming practices. However, chemsex practices may be shocking to those who are not aware of them, and it may have been he was simply reporting on what his experiences were. This space between his reports and what the staff felt they could cope with may have left a gap where support could have been targeted.

[29] https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Equality-and-diversity/LGBTQ-Toolkit/LGBTQ-Learning-Framework-Toolkit.pdf

Practitioners said that they would have liked more training on chemsex and harm reduction advice.

5.2.5 Race – The men included in this SAR were all from white ethnic backgrounds. A previous SAR and several DHRs noted in Section 3 also concerned white men, though one DHR referred to an Asian man. Gay men's health charities shared that those seeking support for chemsex related harms are seeing more younger Black men self-referring and that this is a growing trend over recent years. The SAB should consider if any unintended biases within agencies identifying deaths have missed Black, Asian or other racially minoritised men during case finding. The SAB should ask if diversity has been considered in the Emergency Department (ED) audit on chemsex presentations, should ask SASH and the Club Drug clinic to offer a view around Black, Asian or other racially minoritised men's access to their services and should ask partners to consider racial diversity in their work so that Black, Asian and other racially minoritised men are receiving equitable support around chems where needed.

5.2.6 Dyslexia - Outside of sexual identity and the chemsex context, one of the men reported having dyslexia and being unable to use the internet. However, this was never again mentioned in any agency records and it is unclear whether this was diagnosed or how it affected him (e.g. this may have been an explanation for poor appointment management that was masked by labels of 'non-engagement'). It seems very unlikely that any reasonable adjustments were made for him given the absence of other recording.

5.2.7 Care Experience – One adult was care experienced. The additional dimensions of vulnerability and trauma that this experience added was not always acknowledged fully by care providers. This is discussed more fully in the next section under the topic of transitional safeguarding.

5.2.8 Homelessness and housing – Two of the adults had issues with homelessness and housing. Although one of these adults' placement in the homelessness pathway pre-dated their engagement with chemsex, the other adult became evicted and re-housed around the same time as losing a professional job role and some petty criminal offences. Services who support men who engage with chemsex indicate that for some, chemsex, the associated drugs and the scene in which it takes place can become overwhelming and there are correlations between the drugs and erratic presentations. It is a hypothesis of this SAR that chemsex engagement may have become overwhelming for this man leading to this spiral,

and therefore there may well be an important overlap for housing and homelessness services and chemsex support needs.

Recommendations 4 suggests scoping around race and chemsex. Recommendation 5 suggests a mapping exercise around initiatives to promote LGBTQ+ access to services. See Section 9 for more details.

5.3 – KLOE 3: Learning related to Abuse, Neglect and Exploitation

Learning in summary:
For one adult, safeguarding needs were raised on virtually a daily basis. Yet very few safeguarding referrals were actually made and in these instances, there were signs that further professional curiosity was warranted re: debts to dealers that were quickly resolved. Self-neglect, dangerous substance overdose and risks of sexual exploitation were specific gaps in raising safeguarding concerns. Although the professionals in the services who were most involved work with people with elevated complexity and need, they reported not having a liaison person in adult safeguarding to help them navigate concerns that are encountered on a day to day basis. Resources at the point of transition from children's to adult's services point to learning about commissioning and transitional safeguarding.

5.3.1 Across the chronologies, a range of safeguarding issues were raised for the men in this review including multiple sexual assaults, physical assaults, serious threats to harm or kill the adult (often due to substantial debts related to substance use) and being robbed or mugged. Professionals discussed worrying that one of the men was being groomed or exploited by older men. There was evidence that these risks, patterns and incidents were discussed at service level meetings, though there was less evidence of multi-disciplinary meetings and inconsistent safeguarding referrals. Disclosures of assault were usually vague and often withdrawn (not to suggest the person was saying it did not happen, but their willingness to discuss it was retracted). Consequently, professionals noted it was difficult to know what to do. This also explains some inconsistencies around raising safeguarding concerns. If there are uncertainties about safeguarding referrals, it is still possible to discuss this with the safeguarding team, to consider how to convey this information, seek further information from the adult or take other risk mitigations. One of

the men was the subject of police enquiries as having potential involvement in a sexual assault, though his role was unclear and the police did not take further action. Another adult made complaints to police about being harassed and stalked by a man he met on a hook-up app. He did not wish to be referred to a LGBTQ+ domestic abuse service, though this was offered. He was not deemed suitable for MARAC (high risk multi-agency meeting about domestic abuse) though it is unclear why or whether that decision was made on the basis of a DASH risk assessment.

5.3.2 Practitioners also raised some concerns about self-neglect for one of the men, though this was difficult to discern in the chronologies. The concerns related to neglect of his hygiene, his physical surroundings and his diet, appearing quite emaciated at certain points. Although a housing charity arranged some regular cleaning support for this man, when this was not meeting the need, there was no referral for consideration of safeguarding or other proportionate response.

5.3.3 Only one safeguarding concern was sent for any of the men and this related to threats made towards that man due to debts to dealers, but this does unfortunately appear to have been dealt with very superficially. The enquiry was closed because the adult would not engage but the social worker had spent six weeks trying to call a phone number that was for an old accommodation provider. It is striking to see the adult's engagement being described as a barrier in this context. It was interesting to note that one incident of debt to dealers was raised but another was not and this inconsistency was not explained. The absence of other safeguarding concerns, particularly given the gravity of the concerns above, is also striking. Although some information may have been vague or piecemeal, this can still be discussed with safeguarding services. Specific agencies reported experiences of broader safeguarding referrals (beyond the men in this report and not relating to chemsex) not being accepted and this appeared to have caused some fatigue. Services who work with multiply disadvantaged adults indicated that they do not have a liaison person in MASH or adult social care to consult with. However, sexual assault, self-neglect, threats and assault, and in particular losing consciousness when injected by self or others all warrant safeguarding concerns for adults with care and support needs. Perhaps if the social work team had seen this pattern, an allocation would have occurred and led to consistent support.

5.3.4 Risk to others was a theme that panel members were keen to explore. There was evidence of one adult being questioned on one occasion about a sexual assault, though his alleged role in this was unclear and an anonymous call was received about another adult suggesting they had caused some form of sexual harm, though this was vague. It was not possible to follow up on that given the way this information was shared. In conversation with SASH, a social enterprise who work with sexual health support needs, the grey nature of consent and capacity in the context of intoxication is very complex and people may not feel able to raise concerns about assault due to the Class A and B drugs that are involved and may fear arrest if they seek support.

5.3.5 There were concerns about sexual exploitation given some age difference relationships or contacts for one of the adults, who may have been more vulnerable to exploitation as a result of trauma and his wider support needs. However, there were concerns about how to articulate this or show concern in the context of not wanting to appear homophobic. This is difficult territory. Clearly, adults can consent to sex and relationships with other consenting adults. However, if younger adults are coerced, exploited, groomed, assaulted or even made to feel uncomfortable, it is important that they are able to have conversations with trusted adults, ideally those who share a sexual identity with them or through peer support and LGBTQ+ charities.

5.3.6 There is no evidence of discriminatory abuse being experienced on account of protected characteristics, though the next KLOE on app use and social media notes an incident where one adult was assaulted and this was filmed and there is also evidence of frequent reports of assault for this adult. This may have been associated with debts and non-payment in the later episodes, and details about the earlier filmed assault are unclear, but a hypothesis around possible discriminatory abuse is not possible to rule out.

5.3.7 *Transitional safeguarding* – A sub-theme related to the transition from children's services to adult's services for younger men who are GBMSM. Transitional safeguarding fluidly supports the safeguarding needs of adolescents and young adults across their developmental stages to safely prepare them for adult life[30]. Transitions are processes and not events and traditional binary and silo thinking of children's and adult's services create vulnerability and risk – especially as safeguarding thresholds and policies differ across

[30] Holmes, D. and Smale, E. (2018) Transitional safeguarding - adolescence to adulthood: Strategic Briefing, Totnes: Research in Practice.

these services. This approach works with the needs of the young person rather than the restrictions of the service. There was evidence in this SAR of engaged, multi-agency planning and significant incident reporting to address one individual's complex needs across the threshold of his 18th birthday. However, there was learning in this SAR around the need for more creative commissioning of housing options for individuals with dual mental health and substance use needs. Services involved in the SAR queried whether the housing option that was pursued accelerated the individual's exposure to harder substances and injecting practices and his subsequent chemsex participation on top of this poly-drug use increased his vulnerabilities. A Care Act assessment referral sent before Children's Services closed his case does not appear to have ever taken place, though mental health support was arranged. Children's services provided helpful feedback about a recent structured process for transition planning that has been adopted subsequent to their contact with this man.

Recommendation 6 addresses safeguarding gaps. Recommendation 9 relates to Housing Commissioners and the gaps for those with co-occurring substance use and mental health needs. Recommendation 11 relates to reflective work within Children's / Leaving Care / Transition Services. See Section 9 for more details.

5.4 – KLOE 4: Learning related to Digital Platforms

Learning in summary:
This KLOE was set to address the role of apps and digital platforms in facilitating risk, but app use needs a broader lens, they are facilitative of connection. At the same time, risks did emerge. Across the adults in this SAR, there was evidence of sexual assaults when meeting others via apps and experiences of stalking and harassment. While app use was acknowledged by professionals in one case, app use was not, in itself, discussed with this man with care and support needs in terms of safer app use. Professionals should be careful to guard against heteronormative perspectives on dating, relationships and sex when thinking about app use.

5.4.1 Across the chronologies, there was mention of geo-location hook-up app usage. One of the men discussed his app use with professionals he was in contact with and disclosed sexual assaults, being "drugged" or waking up naked to find a new partner

"touching them" when they remembered being clothed before sleep. Another man reported harassment and stalking from a man he had hooked up with via an app. One of the adults died in the home of a man he met recently via a hook-up app on his first visit to this man. Apps were possibly a method for connecting with others beyond 'hooking up' given the chat history over several weeks before their meeting had been planned. Two of the men used hook-up apps to host or attend hook-ups with multiple partners simultaneously. The men's accounts of this were sex-positive and that this was enjoyable. Professionals who were involved offered consistent advice about contacting the police and accessing sexual health services. As per 5.2.1 above, one of the men was open about his app use with professionals, though they did not know what to do with this information.

5.4.2 Stepping back from the individual men's chronology data to look at broader trends, advocacy organisations shared that crystal meth and GHB/GBL emerged in the 2000s and this coincided with the development of smartphones. Apps became a conducive medium for meeting others, initially through online dating and later through more immediate geolocation features, which allowed app users to see who was nearby and what their sexual preferences are, facilitating an immediacy and spontaneity that was far less available previously. Apps might also allow signalling about chems use. While previous generations may have encountered drugs in clubs and public venues (and this is still a factor), crystal meth and GHB/GBL are not generally used in clubs and are mostly used during sex or sometimes alone. Those participating may know the location they are attending, but not necessarily who – or how many – will be there. For professionals who are not GBMSM or who do not use apps in this way, a heteronormative ideal for dating or relationships may problematise app use and frame it as risky given the unknowns. However, app usage is popular among GBMSM because it enables quick connections and experiences in a world where it may be difficult to tell if others are interested. These dynamics must be accounted for rather than uncritically or unequivocally problematising these technologies.

5.4.3 Advocacy groups suggested that younger men or those who have recently come out may use apps as a safe space to explore their sexuality and meet like-minded individuals. Attending a party where chemsex happens might feel validating, though those newer to the scene may struggle to manage elements of substance use or multiple partners.

5.4.4 – The term “weaponisation” was used by some professionals to describe the ways in which some of these apps and social media hook ups facilitate “darker” elements such as facilitating acquisitive crime. Sexual health clinicians mentioned that some apps have become a “front” for dealing, based on what they are hearing in clinics. Police colleagues and advocacy groups mentioned that apps may be used in the context of organised crime in the context of dealing or blackmail, or that there could be more predatory behaviours whereby an individual might be filmed and blackmailed or after using may be incapacitated and sexually assaulted or stolen from. While this is not necessarily a majority experience of using apps, such risks are acknowledged in pamphlets and information guides from gay men’s health organisations about safer hook ups, encouraging those meeting new hook ups to consider storing valuables in a safe place and setting aside cash in a different place in case they experience theft. These sources also articulate that using apps to meet new people can be a positive but that on arrival, individuals should assess if it feels comfortable and to leave if they detect any red flags. There was limited evidence of “weaponisation” in the chronologies, though one man’s experience of stalking aligns with this description.

5.4.5 – Sexual health and advocacy services noted that one app had built in health promotion work on chems, PrEP, safety and highlighting risks and that some charities from the sexual health arena had been involved in this work. Others noted that they were aware of profiles on apps that were specifically set up to chat and share health promotion and safety information as well as support for other users.

5.4.6 Given research findings around social isolation and disconnection as strong rationales for engaging in chemsex[31], app use may provide a sense of community and belonging for some people. However, public health interventions could consider how other forms of social space or connection can broaden the social resilience of those who are socially isolated. While one man described using apps to feel a sense of connection to other GBMSM, another who did not disclose app use did describe profound loneliness. These statements did not result in suggestions around building community or connection. This would likely involve LGBTQ+-led community spaces, peer support and mentoring and “sober” spaces where those who use can take breaks from or reduce substance use without losing a sense of connection. LGBTQ+ charities provide such spaces but public

[31] See Hawkinson et al (2024) as previously cited

health could look into provision mapping so that health and social care professionals can signpost.

5.4.7 It is notable that this KLOE has less information available in the chronologies. In terms of broader, social media use, there was one episode where a man was filmed while being assaulted and this being shared to social media. App and social media use is something that we all do every day on our phones, and we would not feel we need to discuss this with providers we work with. LGBTQ+ individuals may use apps to make connections that are difficult to do in heteronormative spaces and are therefore a source of social capital. It is difficult to offer a judgement around whether the lack of data indicates a blind spot for professionals or that this an aspect of private life that we are all entitled to. However, while app use was a noted vehicle for safeguarding concerns (exploitation, new drugs, losing consciousness), interestingly I found no discussions about app use in its own right. Indeed, professionals who worked with one of the men and who had been shown his profile felt uncertain about how to respond, as per 5.2.1 above. A useful conversation follow up might have included asking how to he kept himself safe while using these apps, how he managed to draw boundaries and protect himself, how he weighed the benefits of app use against whether they were hindering his ability to engage with recovery. Given his candour, it is possible he would have engaged with trusted staff members around this. The episode where an assault was filmed and shared on social media also highlights a harm that services should consider, potentially under the rubric of discriminatory abuse if he was targeted due to his sexual identity.

Recommendation 4 calls for public health mapping of social spaces for GBMSM and develop brief guidance for practitioners on safer app use drawing on London Friend's experience in the field. See Section 9 for further details.

5.5 – KLOE 5: Learning related to Health Provision

Learning in summary:
Emergency Departments are significant in the identification of chemsex related harms, though they are not necessarily conducive to intervention and disclosure. Nonetheless, protocols and policies should be in place to identify appropriate support in these settings. Primary care is a less likely venue in which chemsex will be discussed, but

there is broader learning around Hep C screening and benzodiazepine prescription in conjunction with mental health and substance use services. Sexual health services who may struggle with substance use issues, while substance use services may not be familiar with sexual health issues, creating a gap when working with chemsex and there are screening and commissioning implications as a result. There is learning for mental health services in relation to 'engagement' issues. Although engagement must be consent-led and person-centred, the context of multiple exclusion and trauma, complicates this perspective. In this multi-disciplinary environment, there was scope for better collaboration through an enhanced vulnerability forum and the Homeless Health team could have been better utilised in one man's instance to enhance integration of service responses. There is evidence of an engaged multi-disciplinary network attempting to support with substance use, offering detox and other support consistently, though this did not necessarily support the wider services to grapple with the unique issues relating to chemsex. There is some learning around gaps relating to co-occurring substance use and mental health or 'dual diagnosis'.

5.5.1 **Emergency Departments (EDs)**

5.5.1.1 Across the chronologies, some of the adults had a high number of ED attendances, sometimes at different hospitals. Two of the adults attended in the context of apparent or confirmed substance use (including withdrawals and seizures) or mental distress (including paranoia or suicidal thoughts). Another attended due to unintended injuries related to sexual practices. On many of these occasions, the men were seen without asking relevant questions (in light of presentations) about substance use. When specific substances like crystal meth or GHB/GBL were named in ED notes, opportunities to ask about chemsex or to offer advice or health promotion signposting were not taken. One of the adults was poorly engaged with his HIV team and links were not made to his sexual health during the ED attendance, which would have been helpful.

5.5.1.2 I met with hospital personnel to discuss the ED interface. They discussed the complexities of working with chemsex-related harms, noting that admissions were often through resus for unknown reasons having been found drowsy and confused or with a presenting complaint of agitation. There were also some self-presentations with concerns about side-effects. ED staff described a variety of responses by people attending - some

were very open and directly disclosed what they had been using and in what context, others were more subtle about their use. This may be a fear of having drug use on their medical records, but ED staff observed that some do not see their drug use as an issue, and that it is just a routine part of their life. Conversations about health and harms were also variable, depending on how open the person was to discussion. ED is a very busy environment with few side rooms and so there is very little privacy in ED and it may not be conducive to disclosing sensitive or potentially stigmatising information about sexualised drug use. Challenges in ED include getting consent from an adult to refer onwards, and staff may not know what services are available given a large workforce and regular doctor rotations. However, hospital practitioners acknowledged that development is needed around professional confidence to talk about specific drug use and associated harms. They acknowledged that it might be difficult to ask about sexual practices unless a sexual assault was being named, where a particular pathway would kick in. This led to a discussion of a protocol in ED signposting to sexual health services, GBMSM health services and the ED were aware of the chemsex safer packs which a gay men's health charity have devised. The ED service seemed enthusiastic about this.

5.5.1.3 Emerging findings from an ongoing ED audit relating to chemsex-related presentations and led by public health was also discussed. Presentations include individuals who have used GBL/GBH or Crystal meth, worried about side effects or suicide. In these cases, histories of trauma and mental health difficulties were often given. Most presentations relate to psychosis and paranoia due to crystal meth usage. ED coding is a challenge as there is currently no code for GHB/GBL, crystal meth or chemsex. NHS England are being lobbied to change this to allow more transparent data.

5.5.1.4 EDs are busy environments which are almost always stretched to capacity and yet they are crucial venues for addressing chemsex related harms as people attend ED services when in crisis and need help with these harms but may not attend other services outside of crisis. It can be important therefore to maximise on opportunities to signpost and briefly educate those needing support despite the challenges of the ED environment. A recommendation has been made to map with this observation below.

Recommendation 2 addresses a need for the development of protocols and policies in Emergency Department settings. See Section 9 for more details.

5.5.2 **Primary Care**

5.5.2.1 Across the chronologies, there was variable contact with primary care. One adult was in regular contact with their GP due to a substantial prescription relating to their substance use and mental health needs. The other two adults did not regularly see their GPs, for one this related to receiving care predominantly from their HIV team. One important observation was that one of the men had tested positive for Hep C in 2022 but did not appear to have been offered treatment or a liver scan for this which the GP indicated would be usual practice. The GP could not find any reason for this and noted that this was a learning point for the Practice.

5.5.2.2 *Benzodiazepine use* - Although not specifically related to the chemsex theme for the SAR, it was notable that two of the adults were on long-term prescribed benzodiazepines. One of them had commenced on this prescription overseas and another was under neurology, psychiatry and substance use leading to a complicated prescription. However, medical and nursing professionals involved in the SAR acknowledged that this was highly unusual as benzodiazepines are usually prescribed for short periods and acute reasons. For one of these adults there were attempts to wean off their benzodiazepine prescription but there were concerns that this was being replaced by illicit benzodiazepine use and for a while the medical practitioners believed it was better to offer supervision around their use. When there was a change of personnel and one service closed his case, there was a change in prescription advice and the benzodiazepines began to be reduced weeks before his death. The GP worked very closely with other specialists at all times. As part of the SAR process, the GP reflected that she wondered if the change of advice on benzodiazepine prescription should have been discussed at more length, but the mental health service indicated that the advice to wean after they closed the case was justifiable and that weaning these drugs has to be assertive.

5.5.2.3 I spoke with each of the men's GPs, who all indicated that chemsex doesn't come up regularly in their practice. They all indicated that sexual health services or EDs were more likely to encounter this and that if they were made aware it would usually be through an ED discharge summary, though none had come across this themselves. They indicated that knowledge was relatively low but that they would signpost or refer to drug and alcohol or sexual health services if they encountered this.

Recommendation 8 addresses questions around benzodiazepine scripting and gaps around Hep C identification and treatment. See Section 9 for further details.

5.5.3 **Sexual health**

5.5.3.1 Across the chronologies, two of the men were known to sexual health services. Another man was signposted and encouraged to attend but expressed worries about doing so and ultimately did not attend. His worries related to fear about the content of results. Some advice was sought from a service that outreaches but this man preferred not to engage. The other two men had regular contact, one via his HIV clinic and the other for regular screening. One notable finding is that for one of these adults, in 50% of his visits, he was not asked (or his response was not documented) a routine chemsex question. In conversation with sexual health services, practitioners confirmed it would be unusual for this question to be left blank. While he may have declined to answer, this is not noted. The other man engaged with sexual health via his HIV clinic, though his attendance was not consistent, and he was not always adhering to treatment. Recall protocols were followed to attempt to re-engage him.

5.5.3.2 Sexual health services for Hammersmith and Fulham operate out of two hospital trusts. At one hospital site, a chemsex clinic was part of the commission from 2015 to 2018 when this was disbanded during retendering. Now, sexual health services refer to drug and alcohol services or more ideally GBMSM health services out of borough (Antidote or Dean Street). Chemsex is part of routine screening and if those attending disclose chemsex, then they are asked what are they using, how are they using it (injection, smoking, nasal) and has anything happened while using it (ED attendances, police contact, blacking out). Services said that the majority of those who share their chemsex use in clinic do not see it as a problem and report this is contained to infrequent sessions. People can attend sexual health services in any part of the country, use pseudonyms if they wish and there are strict confidentiality rules governing delivery in this sector. Staff believed that the co-location of the (de-commissioned) chemsex clinic had been advantageous because they could deal with these issues as part of the general work-up, whereas currently they have to refer on. Given estimations that chemsex prevalence is higher in populations with HIV, this appears to be worth considering when commissioning.

7.5.3.5 Services such as Antidote and SASH also provide psychosexual support and therapeutic support to people who identify chemsex related support needs. SASH were consulted for advice by one service who were struggling with supporting one of the men.

Recommendation 10 addresses routine chemsex screening and a broader question around sexual health and chemsex commissioning. See Section 9 for more details.

5.5.4 - **Mental health**

5.5.4.1 Two of the adults were known to mental health services. One had long-term contact since adolescence when he was known to CAMHS and later transitioned to a Transition team and later a generic CMHT, the other was open for several years to a CMHT. One of the adults had frequent episodes of suicidal ideation and self-harm. He stopped engaging with his mental health team after a change of team and personnel and was ultimately closed to the service due to non-engagement.

5.5.4.2 The theme of non-engagement was of concern to those involved in the review. Of course, engagement must be consent-led, proportionate and non-intrusive. However, this man had not been allocated within the mental health team to a worker as planned. He had also been transferred from one Consultant who he had an established relationship with to another (teams are entitled to make these decisions for an array of operational and staffing reasons, but consideration about the impact of changes should be considered when subsequently describing non-engagement for adults with enhanced vulnerabilities and experiences of trauma). A social worker spent several weeks attempting to contact him at a previous accommodation provider, when he had plenty of more recent contacts with mental health services who were aware of his move several years earlier. He was also engaging with other services. It is difficult to sustain an argument that he was non-engaging in this instance without looking at the engagement strategies of the teams who support individuals. The case closure also came at a point when other services were requesting more collaboration due to increased appreciation of his GHB and crystal meth use and the mental health impacts following several reported sexual assaults. Unfortunately, he died two months later following continued levels of risk and suicidal ideation.

5.5.4.3 Reflections from the mental health service have been helpful as part of this SAR process, with consideration of whether that transfer could have been more effectively managed given that he would sometimes push services away if he felt he was not receiving

consistent care. A team like the complex emotional needs team might also have brought different skills to his case. Mental health services also reflected that his enhanced vulnerabilities might have been better accounted for and more creative engagement skills might have been helpful. They note more consistent advice around sexual assault allegations should have been provided within their team. Within the SAR process, resource issues were noted and appreciated for mental health teams, but the decision to close left the risk entirely with other non-specialist teams when different engagement approaches by the mental health service may have provided an alternative frame. Learning here relates to the importance of trauma-informed practice, flexible responses to 'non-engagement' (particularly given some of his enhanced vulnerabilities) and shared responsibility across agencies when supporting adults with complex needs.

7.5.4.4 In relation to chemsex, the mental health service indicated that despite the mental health impacts that harmful chemsex can result in, they did not feel their service was well prepared if they encountered chemsex presentations, for many workers there would be a taboo around talking about sexuality and therefore chemsex would be a challenge without further training, engagement and development activity.

Recommendation 1 addresses training and workforce development, Recommendation 6 addresses sexual assault pathways and Recommendation 7 suggests scrutiny around how 'non-engagement' is managed. See Section 9 for more details.

5.5.5 **Drug and alcohol use services**

5.5.5.1 LGBTQ+ charities shared with the SAR that many adults who take part in chemsex would not consider this to be problematic substance use and most people they see are not engaged with drug and alcohol services. Even if they do attend these services, they often do not see their needs mirrored in other service users drug consumption patterns or service delivery models that target opiate use in particular. It is therefore not surprising to see that only one of the adults was known to drug and alcohol services, and that his use of GHB/GBL and crystal meth commenced after a much longer pattern of poly-drug use. This adult had access to dual diagnosis support from an independent agency. Although he did not always engage well with the substance use support available to him, this improved significantly when he was allocated to the LGBTQ+ lead for the service who took a creative

and proactive approach to engagement. His substance use drew him into frequent contact with emergency services, including ambulance call-outs and emergency attendances due to overdose. He was given Naloxone and was aware of how to administer it. Multiple agencies were trying to support him around these needs. Support was generally collaborative, though there were relatively few multi-agency discussions noted in the chronology. His engagement was based on rapport, and he was open about the risks he was taking with those he trusted.

5.5.6.2 LGBTQ+ charities and substance use services indicated that his use of heroin was not the usual presentation for someone using drugs in the context of chemsex. There was a suggestion that his use of GHB/GBL and crystal meth may have been a way of accessing substances of any description. However, as a gay man who had experienced significant trauma and without a large LGBTQ+ network, there is a bigger context to his engagement with these substances.

5.5.6.3 While his engagement with the substance use team increased due in large part to the LGBTQ+ worker's approach, this did not necessarily mean that he had any sustained contemplation to change his substance use levels, outside of remorse following emergency situations. He was consistently offered detox but seemed reluctant or ambivalent about this. The relationship-based engagement approach was important to provide informal forums to drug use.

5.5.6 More generally, with regard to one individual, the homeless health team reflected that other health services did not consistently involve them even though their brief is to in-reach into hostels, including to support engagement with health teams. They described that they were not invited to MDT meetings and they could have played a valuable role and had tried to do so. This team work across various boroughs and noted that a neighbouring borough has what is termed an 'enhanced vulnerability panel' for escalating concerns about those living in hostels where the support of multiple agencies is needed.

Recommendation 6 recommends establishing an Enhanced Vulnerability Panel and Recommendation 8 calls for joint work and assurance across relevant services to assure the SAB. Recommendation 9 recommends wide dissemination of the Homeless Health Team remit. See Section 9 for more details.

6. Recommendations

Recommendation 1 – Training and awareness on chemsex and related issues

The SAB should commission a multi-agency learning event arising from this SAR around the theme of chemsex harms. All SAB agencies should contribute and provide assurance to the SAB, through a documented learning summary and evidence of dissemination via internal governance and training structures, on how learning about chemsex has been shared within their agency. This should include input on flags for chemsex engagement and how to ask appropriate questions. The SAB should cover links with sexual exploitation to support a better understanding of how to identify and discuss this if concerned. Attention should be given to the missed safeguarding referral opportunities and the hostel and other supported housing services should be key stakeholders.

Recommendation 2 – Chemsex and Emergency Departments (including coding)

The two hospitals serving Hammersmith and Fulham residents should develop a protocol for patients who attend ED in the context of chemsex, GBL/GHB and crystal meth use. This protocol should integrate existing health promotion packs from London Friend / Antidote. They should report progress back to the SAB. Emergency Departments may need to commission their own training and should consider how doctor rotations can be accounted for and how it can fit alongside existing training on safeguarding or substance use. Additionally, the ICB should escalate a recommendation to NHS England that ED coding be revised to include codes for GHB/GBL, crystal meth and, if possible, chemsex. The SAB should consider additionally raising this through the SAB Chairs and Managers group.

Recommendation 3 – Chemsex and Policing

The SAB should ask the Metropolitan Police to offer assurances that criminality has been ruled out, that features such as delayed calls to emergency services have been accounted for and to offer an explanation around the lost toxicology report and assurances as to how the risk of this occurring in the future can be minimised.

Recommendation 4 – Chemsex pathways, commissioning and public health initiatives

Public Health should consider (1) mapping how the needs of racialised minority GBMSM men engaged with chemsex are being supported locally, (2) developing brief guidance for practitioners on safer app use drawing on London Friend's experience in the field, (3) map

provision of social spaces for GBMSM or the wider LGBTQ+ population in the borough, including sober spaces. The outcomes should be shared across partner agencies.

Recommendation 5 – Wider LGBTQ+ initiatives, access to services and support

The SAB should ask all partner agencies to (a) report on initiatives they have run in the last year and plan to run this year to directly support LGBTQ+ individuals accessing their service or to support the workforce with this work and (b) form a view around any gaps in provision considering the findings of this SAR. An outline of upcoming events should be centrally shared if there is value in doing so once agency plans are understood.

Recommendation 6 – Safeguarding and 'high risk' processes

Adult social care should ensure that local hostels have access to a liaison or link worker to discuss referrals and concerns given high levels of vulnerability in this pathway and the common problem of incomplete data about risks.

The SAB should consider the proposal of the enhanced vulnerability panel and consider where this might sit, how it would intersect or overlap with other high risk panels and if another existing forum should be widened or advertised to ensure awareness.

Recommendation 7 – Mental Health recommendations

The mental health service should provide assurance to the SAB, through a governance report, that staff across the Trust are aware of and consistently use appropriate LGBTQ+ domestic abuse referral pathways.

The mental health service should assure the SAB, via a sample case audit and evidence of managerial sign-off, that case closures for "non-engagement" across community mental health are subject to consistent oversight and safeguarding risk assessment.

The mental health service should assure the SAB, using training compliance data and quality assurance audits, that its Trust-wide workforce complies with existing policy on responding to disclosures of sexual assault.

Recommendation 8 – Primary and integrated health / mental health recommendations

The mental health service and drug and alcohol services, should assure the SAB, through a jointly approved protocol and governance review, of the effectiveness of current arrangements for co-occurring substance use and mental health (dual diagnosis). It would

be helpful to include homelessness service or health and homelessness representatives in this review given their expertise with the target group.

Primary care, mental health and drug and alcohol services should audit and jointly report back to the SAB on patients who have been on a benzodiazepine prescription for more than six months or who are known to be purchasing illicit benzodiazepines, consider practices in these cases against national prescribing benchmarks and best practice.

The specific GP Practice should do an audit of Hep C positive cases to ensure that their patients who have Hep C are being appropriately referred for liver scans and treatment.

Recommendation 9 – Housing and Homelessness Recommendations

Housing Commissioners should be asked for comment on the gap for individuals who have co-occurring substance use and mental health needs ('dual diagnosis'), particularly where overlaid by additional vulnerabilities such as care leaving status.

The Homeless Health Team should consider re-advertising their service assertively and strategically to all relevant SAB partners.

Recommendation 10 – Sexual Health Recommendations

Sexual health services should ask staff who do routine screening do a random selection mini-audit on routine screening paperwork to see if the chemsex question is causing problems in clinic or why it might have been left blank on three occasions.

Commissioners for sexual health and drug and alcohol services should be appraised of the gap that sexual health services have shared around co-location of sexual health and chemsex support. They should ascertain the views of London Friend around this proposal.

Recommendation 11 – Children's / Leaving Care Service recommendations

Children's services should hold a learning reflection event on the positive aspects and dimensions of learning about transition planning in this case so that awareness of these issues is shared in their service.

END