



Viewpoint

Exclusion of LGBTQ+ people from the UK's alcohol and other drug-related death response



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Driven by longstanding social inequality, policy stagnation, and an increasingly toxic, adulterated, criminalised drug market, the UK has experienced sustained increases in mortality from alcohol and other drugs over the past decade, with recent rates unprecedented in national records (Holland et al., 2023). Despite the scale of this crisis, public health discourse frequently treats people who use substances as one homogenous group, obscuring structural drivers that concentrate harm within marginalised communities. In January 2026, the Office for National Statistics (ONS) reported that lesbian, gay, bisexual, and other sexual minoritised (LGB+) people face a 1.8-fold greater risk of alcohol-specific death and a 2.8-fold greater risk of “drug-poisoning” death than the heterosexual population (Office for National Statistics, 2026). This represents the first national quantification of sexual orientation disparities in substance-related mortality in England and Wales, providing an opportunity to reassess longstanding but insufficiently addressed inequities. While official mortality statistics for transgender and gender diverse (TGD) people are conspicuously absent from national reports, available evidence is similarly concerning. TGD people are disproportionately represented in LGBTQ+ coronial records (Roberts et al., 2026), and Clinical Practice Research Datalink (CPRD) analyses show that TGD people have “accidental poisoning” mortality rates 2.3 and 5.2 times higher than cisgender men and women, respectively (Berner et al., 2023). LGBTQ+ communities face a disproportionate risk of drug-related mortality, yet this inequity is overlooked in the national response to substance-related harm.

Whilst all drug use confers some level of risk, LGBTQ+ people, like the wider population, use alcohol and other drugs for diverse reasons, often without a significant negative impact on their lives. However, in

some situations, drug use leads to greater challenges and significant harms. More than three decades ago, the minority stress model conceptualised how chronic exposure to stigma related to minoritised sexual orientation (and later gender) creates a unique burden of psychological distress, that can lead to riskier patterns of substance use as a coping mechanism (Meyer, 2003). Subsequent meta-analytic evidence demonstrated higher prevalence of alcohol and other drug dependence among LGB+ people, relative to heterosexual counterparts (King et al., 2008). Taken together, these findings indicate that disparities in substance use and related harms among LGB+ populations have been recognised for decades, yet their translation into national drug policy remains limited.

Paradoxically, environments where these substances are consumed offer, for some, the only relatively safe place for sexual or gender identity exploration and celebration (Connolly et al., 2025). In a society that remains predominantly cisheteronormative and frequently hostile, LGBTQ+ venues are critical sites of community connectedness (Connolly et al., 2025). However, these spaces are typically “alcoogenic,” associating social cohesion with a culture of excess (Connolly et al., 2024). These risks are amplified by commercial influences, with alcohol marketing frequently co-opting themes of “pride” to normalise heavy consumption within LGBTQ+ communities. Similarly, criminalised drugs are increasingly available on LGBTQ+ social platforms, including those used in chemsex (Bourne et al., 2015), an environment often neglected by harm reduction efforts.

Despite these disparities, the UK has failed to meaningfully recognise and operationalise the needs of LGBTQ+ people within national strategies to reduce alcohol- or criminalised drug-related harm. The most

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recent UK drugs strategy includes a brief reference to services being ‘agile to the needs of...people who are LGBT’ (United Kingdom Home Office, 2023). However, without clear operationalisation, funding mechanisms, or evaluation metrics, such statements risk remaining aspirational.

Research suggests most services are characterised by heteronormativity and gender binarism, with staff insufficiently trained to meet the needs of LGBTQ+ people (Connolly et al., 2024; Murray et al., 2024). Residential units and 12-step fellowships often follow binary-gendered models for accommodation and sponsorship, leaving some LGBTQ+ people feeling ‘othered’ or unsafe. Within 12-step settings, groups are often experienced as safer for men; even those purporting to serve LGBTQ+ communities have been reported to be more accessible to cisgender white gay men, while cisgender women and TGD people describe barriers to participation and acceptance (Dimova et al., 2022). Consequently, many LGBTQ+ people attempt cessation without external support, as the specialised “by and for” services that many prefer remain chronically underfunded and geographically inaccessible (Connolly et al., 2024).

These barriers are compounded by a “data void” that prevents strategic commissioning for LGBTQ+ people. The National Drug Treatment Monitoring System does not currently record gender and does not permit routine disaggregated analysis of treatment access or outcomes by sexual orientation. Consequently, disparities in access, retention, and outcomes among LGBTQ+ populations cannot be systematically assessed. Where socially sensitive data are collected but not transparently analysed to evaluate equity, their potential to inform service improvement is substantially limited. Guidance on LGBTQ+-specific commissioning remains vague and lacks practical detail (Office for Health Improvement & Disparities, 2022). Currently, most existing services appear limited to chemsex support. Service adaptations are often limited to the employment of a single LGBTQ+ support worker who cannot fully support the needs of culturally heterogeneous LGBTQ+ sub-populations with a diverse range of substance use and service experiences.

The 2026 ONS statistics have begun to quantify the “rainbow gap” in mortality for LGB+ people (Office for National Statistics, 2026). To achieve a more complete picture of these disparities, future reporting should include differences in the specific drugs associated with these deaths (Roberts et al., 2026), alongside the disaggregation of data by

gender identity and modality (i.e., trans status). Furthermore, qualitative research is required to understand the unique contexts and factors contributing to death among LGBTQ+ people compared to their cisgender heterosexual counterparts. Inequity must be appropriately and inclusively described to further emphasise the case for sustained investments to achieve meaningful change.

Additional funding for substance use services is welcome; however, more of the same will not meet the needs of LGBTQ+ people. The UK must dismantle the structural barriers and stigma that render LGBTQ+ people invisible in both data and care, prioritising cultural humility among all staff, data visibility, and specialist, peer-led service provision, while tackling upstream determinants (e.g., inaccessible gender-affirming care) of substance-related harm. Table 1 outlines our recommendations to public health and drug policy professionals in the UK, intended as a starting point for discussion rather than a product of formal consensus or an exhaustive list.

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Dean J. Connolly: Writing – review & editing, Writing – original draft, Conceptualization. **Caroline S. Copeland:** Writing – review & editing. **Adam Holland:** Writing – review & editing. **Adam D.N. Williams:** Writing – review & editing. **Gillian W. Shorter:** Writing – review & editing, Conceptualization.

Declaration of competing interest

In the last three years, DJC and AH were co-chairs of the Faculty of Public Health Drugs Special Interest Group. AH is a member of the Drug Science Enhanced Harm Reduction Working Group (DSWG), and a volunteer harm reduction adviser for The Loop, a drug checking organisation. GWS is President of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol and Vice Chair of the DSWG. The remaining authors declare that they have no known competing financial

Table 1

Policy and clinical recommendations to address the “rainbow gap” in alcohol and other drug-related deaths.

1. Inclusive data systems and surveillance

The ONS, NDTMS, service providers and coroners must move beyond only reporting sex (typically that assigned at birth) to include mandatory, inclusive measures of sexual orientation, gender identity and trans status. Collecting these data addresses the informational erasure of TGD and LGB+ lives in morbidity and mortality surveillance and could inform more inclusive service planning.

2. Clinical competence and cultural humility

- Substance use service commissioners should mandate LGBTQ+ cultural humility and trans-affirmative training for all service practitioners and facilitate outreach training to local primary (e.g., general practitioners) and secondary (e.g., emergency department clinicians) care providers.
- Clinically, services should collaboratively meet the needs of LGBTQ+ clients (e.g., gender-affirming medical interventions should be recognised as a component of harm reduction for those whose substance use is a response to untreated gender dysphoria).

3. Targeted harm reduction and community spaces

- Funding should be ring-fenced for specialist “by and for” LGBTQ+ digital and, where feasible, in-person services, which are preferred by the community over the existing treatment model.
- Local authorities should encourage investment in and prioritise licensing for alcohol-free LGBTQ+ community spaces.
- Harm reduction initiatives should be tailored to the specific needs of LGBTQ+ populations. For example, drug checking services could be expanded to reach chemsex participants, while needle exchanges could offer supplies for grey market hormones to better engage TGD individuals.

4. Tackle upstream determinants of morbidity and mortality

- TGD people increasingly use substances to manage gender dysphoria and related suicidality (Connolly et al., 2024, 2025). Barriers to accessing bridging prescriptions*, gender dysphoria clinics and ongoing shared care must be urgently addressed to mitigate this determinant of substance-related harm.
- Toxic political discourse surrounding LGBTQ+ (particularly TGD) lives facilitates hostile press and social media and state-sanctioned violence against LGBTQ+ people. Public health professionals should challenge this rhetoric and advocate that politicians uphold their commitments to safeguard LGBTQ+ communities to reduce the burden of minority stress and associated substance-related harm.
- Further work is needed to understand and address the specific barriers to mental health services experienced by LGBTQ+ people who use alcohol and other drugs. The pathologisation of LGBTQ+ people has created a culture of fear, healthcare delay and avoidance exacerbated by rising anti-LGBTQ+ hostility.

Notes.

* gender-affirming hormones prescribed prior to gender dysphoria clinic assessment, often as a harm reduction measure; LGBTQ+: lesbian, gay, bisexual, transgender, queer and other people minoritised based on their sex, sexual orientation or gender; NDTMS: National Drug Treatment Monitoring System; NHS: National Health Service; ONS: Office for National Statistics; TGD: transgender, non-binary and gender diverse.

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